



You just get on and do it: healthcare provision in Youth Offending Teams

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Executive summary

We know from the literature that children and young people in the youth justice system are at high risk of multiple health inequalities and poor life chances and as such are a key target group for health services charged with narrowing the gap in outcomes between the highest and lowest achieving children. Barriers to progress include higher than average:

- Mental health vulnerabilities,
- Levels of learning disabilities,
- Levels of speech and communication needs,
- Health inequalities,
- Rates of problematic drug and alcohol use.

Research indicates that these young people are less likely to have their needs identified early in primary care or school settings. We also know that their needs remain under identified and supported after entry into the Youth Justice System.

In 2007 the Department of Health commissioned the Centre to conduct a study of health care provision in YOTs in England, and also to review mental health diversion work along the youth justice pathway to contribute to our understanding of how these services might be better developed to improve outcomes for young people and their families.

Specifically, the Centre was asked to explore:

- levels of mental and physical health care provision in YOTs¹
- commissioning models for health and mental health provision
- the extent to which health services and interventions offered matched documented need
- access to health care interventions along the whole youth justice pathway.

Methodology

Between August 2007 and December 2008 visits were made to 20 Youth Offending Teams (YOTs) serving both rural and urban communities. Semi structured face to face interviews were completed with 55 professionals including YOT health practitioners, YOT health service managers, YOT managers, commissioners, CAMHS service providers, substance misuse workers. In addition:

- Telephone interviews were also completed with a further 10 YOT health practitioners and with six adult mental health court liaison sites identified in a 2008 NACRO audit as delivering a mental health diversion service to under-18 year olds.

¹ A separate review was commissioned to investigate models of drug and alcohol provision in YOTs.

- A postal survey was sent to 13 YOTs identified in Youth Justice Board returns between 2007 and 2008 as having no health practitioner.
- Visits were made to six adult court mental health teams and to 2 youth courts.

Finally desktop research was conducted to draw together the evidence base and rationale for health input into YOTs, to review relevant learning points from YOT inspectorate reports and to establish best practice principles for the study.

Models of provision

We identified a wide range of different disciplines employed in YOT healthcare teams, and a wide range of different models of provision. These included:

The lone health practitioner model

Practitioners tended to be located full time in the YOT with low level linkage to local health teams.

The foot in–foot out model

The health practitioner typically had a presence in the YOT team as well as good systematic clinical and operational links with a specific local health team.

The virtual locality health team model

Health workers are located in the YOT and also have strong operational and clinical links with a specific health team outside the YOT; in addition they have developed systematic linkage, networks and joint working practices with broader health and mental health workers in the local area.

Outreach consultative model

We found some examples of an outreach consultative mental health model. This type of service not only provided direct services to very high risk and/or to vulnerable young people in the region or locality, it also provided supervision and clinical and telephone support to health workers in YOTs, in custodial settings, in specialist CAMHS as well as others throughout an area or region.

The internal YOT health team

In some areas, a team of health practitioners have been pulled together in a YOT. Often this type of team has an internally located YOT health manager.

The external YOT health one-stop-shop

Some YOTs had no health presence in the YOT but young people's needs were served through being referred to an external resource specifically commissioned for vulnerable young people in the area.

Each of these models demonstrated strengths and disadvantages. Health practitioners voiced the greatest concerns about the lone practitioner approach. Many workers described feeling professionally isolated and facing persistent struggles with accessing mainstream and specialist health and mental health provision for children and young people in contact with the YOT. Lone health practitioners often ended up working directly with young people and did not always fulfil the originally intended role of being a bridge to mainstream services. In teams with lone workers, what was provided also tended to reflect the professional expertise of the worker in place; so, for example, physical health workers tended to have built a service based on broad health screening whilst mental health workers focused on mental health and emotional well being.

In determining the best model, commissioners and YOTs should be aware of the range of different YOT health commissioning models available and make decisions taking into account a needs assessment of all vulnerable young people in the area, whether the YOT is in a rural or urban setting, an audit of what other services (voluntary and statutory) are available in a locality and in the region and any overlap in the focus of these services, the extent of difficulties faced in accessing local specialist services, stakeholder consultation and the evidence base.

Barriers to effective provision

We found that most health and therapeutic support was focused at a very late stage in the youth justice pathway usually at the point that a young person was placed on a supervision order (or what has now changed to the Youth Rehabilitation Order). Before this, in most instances standard YOT ONSET or ASSET assessments were completed. We know from research that these tools under identify health inequalities, emerging mental health difficulties (especially when these manifest as behavioural difficulties) and speech and communication needs if these are not perceived by the practitioner as being directly linked to any risk of further offending. If left unidentified and unaddressed at this point of arrest stage, needs can remain unmet sometimes for a number of years as young people move through the pre court system compromising their life chances and safety as well as sometimes undermining the safety and well being of local communities.

We found that young people often face persistent problems accessing support from mainstream specialist health and social care services. This appears due in large part to inflexible exclusion criteria, failure to recognise multiple and safeguarding needs, and poor design of services that are not experienced by young people as accessible or engaging. These service design issues require urgent attention by commissioners.

We found that many health practitioners were holding on to young people in silos in YOTs. They were often providing services without the back up of strategic support from local commissioners.

Without clear pathways into a range of mainstream local services backed up by well developed formal agreements, these workers struggled to get young people linked up with the range of provision best placed to meet their multiple needs.

There is a current gap in provision within the youth justice system for children and young people with mild to moderate learning disabilities and a lack of clarity as to whether speech and communication needs can realistically be met by local services. These issues require careful consideration by local commissioners and regional leads.

There is under developed therapeutic provision for those with conduct problems and emerging personality disorders. For example, there was low awareness of the therapeutic significance of early starting behavioural difficulties and scope for more consistent linkage between YOTs with evidence based parenting and family therapy services to support the needs of these young people.

Children and young people in custody have the highest needs and are not presently receiving the intensity of evidence based therapeutic support required to reduce reoffending risks and improve their life chances and their resettlement. There is a need for greater use at the point of release of evidence based approaches such as Multi Systemic Therapy, Functional Family Therapy, Family Integrated Transitions as well as those with promising signs of effectiveness such as Family Intervention Projects and intensive wraparound services.

A wide variety of health and mental health assessment tools are currently being used in different localities, across different agencies and even at different stages in the YJS pathway.

- The Common Assessment Framework was not commonly used in YOTs during the currency of this study.
- Most YOTs used a common screening tool for mental health called the Short Questionnaire Interview for Adolescents (SQIFA) but this did not screen for learning disabilities or speech and communication needs.
- Many YOT health practitioners used specialist assessment tools which were consistent with what was being used in local mental health services to improve the chances of referral. These specialist assessment tools often varied between regions and were embedded in health trust practice and would be difficult to change.

A number of reviews by different government departments continue to try and rationalize and clarify the most pragmatic way forward to improve holistic and specialist screening and assessment procedures for young people in the youth justice system.

Court psychiatric reports are commissioned in different ways, vary in quality, usefulness and cost, and can have recommendations which don't always link in with what is available locally. In some areas, if a young person is on the CAMHS caseload, practitioners are expected to complete reports for the court; in others only identified specialists feed into the court process.

Health gains made in custody are often compromised during the transition out to the community and require more attention from commissioners at the point of resettlement and release.

There are gaps in mental health and learning disability services for young people aged between 16 and 18 years, and specifically services to support the transition from child to adult services. Consideration should also be given to improving the design and delivery of adult mental health and learning disability services to suit the needs of young adults. This transition point is an important opportunity to intervene early with emerging mental health and health difficulties.

Learning points for improved commissioning

This study builds on the work of earlier audits and good practice guidance to highlight and reinforce some essential elements of an effectively commissioned model to support the health needs of young people at risk of offending and in contact with YOTs. These include:

Improve needs assessment

Completing an annual health needs assessment of all vulnerable young people in a local area (including those in secure settings) as well as an audit of the full range of statutory and voluntary services locally to review and to inform commissioning developments.

Placing a proactive and knowledgeable PCT representative on the YOT management board to highlight the therapeutic and health inequality needs of young people in YOTs, to troubleshoot service delivery problems, to support the development of care pathways and to feedback to local and regional commissioners.

Intervene earlier

Efforts to address health and offending in the youth justice system need to build on a firm foundation of non-stigmatising identification and intervention with children as early as possible, using evidence-based parenting approaches, to prevent multiple adverse outcomes and reduce risks of re-offending.

Health, children's (and some adult) services outside the youth justice system should take primary responsibility for these children and young people's outcomes at this earlier stage in their pathway by linking families up with engaging, cost-effective and proven family based interventions. This care pathway should also highlight the importance of school staff in picking up emotional, developmental and behavioural barriers to the achievement of children's potential learning, providing clear pathways to accessible, timely and non stigmatising early family support.

Establish clear care pathways

As young people risk entry into the Youth Justice System, mainstream health, children and YOT commissioners should build further on this early intervention care pathway. Commissioners

should collaborate to outline clearly which services (a combination of YOT, mainstream and voluntary services) are best placed to meet the range of multiple needs experienced by these children and young people when they are on the fringes of early criminal activity right up until their resettlement after custody.

The suite of care pathways for all stages of this journey should reflect the needs of the population (including the shape and type of services they prefer) and the evidence base for what works. Pathways will need to include physical health problems, speech and communication needs, mental health and behavioural difficulties as well as clarifying care pathways for those with mild to severe learning disabilities.

The pathway should start with a thorough broad-based health screen of all children and young people at the point of arrest, ideally building on previous information available from contact with mainstream services. This system should be established through collaboration between the police, YOTs, the PCT and children's services and should identify risk factors for poor mental health and other adverse outcomes early. The non stigmatising identification, at this stage, of young people who have a history of behavioural problems that start below the age of 10 should be a priority so that resources can be targeted early to support improved outcomes. Young people should be assisted at this early stage to access mainstream packages of support. Where there is a high risk of re-offending and the young person continues through the youth justice system, any progress made since arrest should be reported back to courts and to YOT teams and may inform decisions later on Youth Rehabilitation Orders. This health screen should build on and enhance current community health screening procedures and should be integrated with Common Assessment Framework and Youth Justice screening.

Improve joint working between agencies

Fast track arrangements for specialist assessment should be negotiated between YOT and health and children's commissioners.

Commissioners should ensure a troubleshooting procedure for problem solving difficulties with accessing services, for example when young people have multiple medium level needs and don't meet the thresholds or face challenges because of their age at crucial transition points.

Service Level Agreements (SLAs) should be established and reviewed with other mainstream agencies who are also responsible for jointly supporting the needs of young people in the youth justice system. Clarity is particularly required regarding the part played by mainstream services and YOT in supporting resettlement after custody to ensure that young people have access to intensive evidence based interventions promoting future life chances.

- SLAs supporting YOT health practitioner work should include contingency plans to cover gaps (in excess of six weeks) in the availability of healthcare staff due to turnover and absenteeism.

- When developing and mapping these care pathways and SLAs, commissioners and YOT health practitioners should recognise the important part played by evidence based parenting interventions when supporting children and young people to make changes to long standing behavioural difficulties. Other important approaches are those which support changes in the young person's relationships with the broader systems that form part of their day to day experience (schools, accommodation, family, friends, employment etc)
- Service Levels Agreements should have a clear agreed framework and process for all parties to measure improved outcomes for young people with behavioural, health and mental health needs in contact with the Youth Justice System.

Involve and engage widely

The care pathway will need to emphasise the importance of all those working in the YJS (e.g. police, police custody healthcare teams Appropriate Adults, CPS, etc) increasing their vigilance for indicators for poor outcomes right at the point of entry into the YJS.

The work on developing care pathways for those in contact with the youth justice system should be actively shaped by children and young people with experience of the Youth Justice System.

YOT health teams should also be expected systematically to track their rates of engagement with BME groups and compare these with the minority ethnic profile of YOT caseloads, to ensure equity and accessibility of provision. Commissioners and providers should make contact with BME community development workers for mental health to support the development of culturally competent services.

Speed up psychiatric report delivery

Echoing the findings of Lord Bradley's report, there is a need for a review of the way in which psychiatric reports are commissioned and ordered, with a particular focus on Youth Courts. YOT Health workers should provide systematic feedback to courts on lower level health issues (see, for example, the adult South West Court Report Pilot) and could be better used to advise and co-ordinate input when psychiatric or psychological assessments are required

A checklist of the key health activities and functions required to meet the needs of young people across the entire youth justice pathway has been drafted as part of this study for use by local and regional commissioners as a mapping tool and action plan to guide service design and development.

Learning points for improved health provision

Health practitioners working alone need support. As well as receiving operational management within the YOT, health practitioners on their own in YOTs need good quality systematic

operational and clinical links with a designated mainstream health or mental health team (ideally with a similar focus on vulnerable young people). This will mean attending these teams on a regular basis for training, clinical supervision, and team development opportunities.

YOT health practitioners need a clear set of care pathways with fast track arrangements for specialist assessment negotiated and clarified and a procedure for troubleshooting if children and young people are bounced back from specialist services and risk falling between the cracks of services. This will be even more important when workers are functioning alone in YOTs.

Some YOT physical health practitioners, especially in urban areas, benefit from creating local networks or virtual teams with other practitioners such as Looked After Children nurses, Safeguarding nurses and school nurses. Some practitioners in rural areas have created virtual teams linking up with specialist mental health teams for vulnerable young people or with forensic services.

All health practitioners in YOTs benefit from having access to pragmatic and outreaching expert consultation from a range of specialists (but particularly those with knowledge of health inequality work, sexually harmful behaviours, paediatrics, forensic mental health, Looked After Children, dependent substance use, speech and language problems, learning disabilities, etc) to support the multiple and sometimes complex needs of young people in the YJS. For example, in some local areas systematic consultation offered by specialists had extended the skills and professional development of YOT health practitioners, YOT case workers and CAMH workers. In this way specialist services were able to spread resources further and facilitate effective therapeutic outreach work by frontline workers to young people in contact with YOTs. It means that young people do not have to be referred and passed on to specialists and meet new workers, particularly in circumstances where they are nervous of accessing mental health services. There were examples of consultative approaches working in both urban and rural settings. One consultative approach was commissioned on a regional basis to make the service more cost effective. Where these consultative services had been regionally commissioned it also appeared to improve the consistency of what was being provided from YOT to YOT and, in some cases, between secure settings and YOTs.

When health teams are located outside the YOT, there is still a need for staff providing this health service to make regular systematic visits to the YOT to consult with YOT case managers or health practitioners and to talk through problems with accessing services and meeting need.

Where YOTs have an integrated health team (including physical health, mental health, speech and language workers, substance misuse workers etc) commissioned in the YOT itself, it is still important for workers to forge systematic links with the broad range of voluntary and statutory services outside the organisation to ensure that YOTs do not become isolated from mainstream services. The importance of voluntary sector provision for young people with a range of vulnerabilities but particularly those who are nervous of mental health services or who have mild to moderate learning disabilities has been highlighted during the course of this audit.

When young people have been receiving specialist care in secure settings, access to community based specialist CAMHS or transition services should be fast tracked with immediate contact guaranteed on release. The Care Programme Approach, which aims to improve coordination and continuity of services for those with high mental health support needs, should be used in all such cases. Community CAMH services should adopt an assertive outreach approach to maximise engagement backed up by lone worker policies to support out of office work.

Introduction

In 2007 the Department of Health commissioned Sainsbury Centre for Mental Health (the previous name of Centre for Mental Health) to conduct study of health care provision in Youth Offending Teams (YOTs) in England, and also to review mental health diversion work along the youth justice pathway.

Specifically, we were asked to explore:

- levels of health care provision in YOTs
- type of health services and interventions offered and any unmet needs
- access to health care interventions along the youth justice pathway.

The youth justice system

The youth justice system differs from the adult criminal justice system to reflect the fact that children have a different level of mental capacity, experience, maturity and different developmental needs (Sentencing Guidelines Council, 2009). The legislation reflects these differences between child and adult offenders and also recognises the different responsibilities and duties that society and services have to children.

The legislation is characterised by a preventative focus, and an explicit concern for the child or young person's welfare. Section 37 of the Crime and Disorder Act 1998 sets out as the principal aim of the youth justice system to prevent offending by children and young people. Section 44 of the Children and Young Persons Act 1933 makes the welfare of the child paramount: "Every court in dealing with a child or young person who is brought before it, either as an offender or otherwise, shall have regard to the welfare of the child or young person, and shall in a proper case take steps for removing him from undesirable surroundings, and for securing that proper provision is made for his education and training." Finally, a court sentencing a young offender is required to be aware of the range of international conventions that emphasise the importance of avoiding 'criminalisation' of young people while ensuring that they are held responsible for their actions and, where possible, take part in making reparations for the damage they have caused.

Nationally, the youth justice system is overseen by the Youth Justice Board (YJB). Locally, the Youth Offending Service (YOS) within each local authority is responsible for delivering the youth justice system. Youth Offending Services work preventatively with young people at risk of offending as well as those who have been arrested and dealt with formally through cautioning or in court. Every YOS includes a number of YOTs and Youth Inclusion and Support Panels (YISPs), depending on the size of its population. YOTs are the main vehicle for work with children and young people who have offended or who are considered at risk of offending. YOTs bring together a range of agencies and disciplines in a 'one-stop-shop' team that must, by law, include representatives from the police, Probation Service, social services, health, education, drugs and alcohol services and housing officers.

In England any child over the age of ten can be arrested and charged with a criminal offence. However, YOTs can work more informally with children from age eight, to prevent future offending. After age 10, young people are initially diverted from entry into court through the use of cautions or 'pre-court' disposals. If they continue to offend they must attend local Referral Order Panels (made up of lay representatives) or, for more persistent or serious offences, they appear before specially trained magistrates in the Youth Court. If their offence is very serious they can appear before the Crown Court. At the age of 18, young people move into the adult criminal justice system.

The sentencing Guidelines Council states that courts, in keeping with their duty to consider the welfare of the child, must have full awareness of and information on the whole range of needs affecting young people who offend, including those related to mental health, learning disabilities, vulnerability, and experiences of loss and abuse (Sentencing Guidelines Council, 2009).

Methodology

We visited 20 YOT health teams/workers in the period August 2007 to December 2008, and conducted 55 semi-structured interviews (see topic guide in appendix) with YOT health practitioners and health or YOT team managers. Eight commissioners with responsibility for YOT health workers were also interviewed.

In addition, a postal survey was sent to 13 YOTs that had previously been identified in Youth Justice Board returns between 2007 and 2008 as having no health practitioner, to investigate these reported gaps in provision. Telephone calls were made to eight of these teams to follow up their responses.

Telephone interviews were also conducted with:

- a further 10 YOT health practitioners to establish to what extent they systematically provided input at the prevention/early intervention stage (point of arrest, pre-court etc)
- six adult criminal justice and diversion and liaison sites identified in a 2008 NACRO audit as delivering a diversion service to under-18 year olds).

YOTs were initially selected on the basis of geographical location to ensure a regional spread. Attempts were also made to include YOTs serving urban and rural communities. Where different models of commissioning or diversion were identified by practitioners as the project progressed, these were also visited.

The study team visited six further adult criminal justice liaison and diversion sites and two youth courts to get a clearer understanding of how these worked and the implications for the health and well-being of their clients.

Desktop research was conducted to draw together the evidence base and rationale for health input into YOTs, to review relevant learning points from YOT inspectorate reports and to establish best practice principles for the study.

The study team liaised with and drew on two similar studies: a parallel NACRO study of models of health provision in Wales (unpublished to date) and a study by the Care Services Improvement Partnership (CSIP) and the Health and Social Care Advisory Service (HASCAS) looking at health input into YOTs across London (CSIP & HASCAS, 2008).

The study looked only at models of health and mental health provision in YOTs. It did not include substance misuse work (which was the subject of a parallel investigation by the Department of Health), although this was often interlinked with health work and was included in so far as YOT health practitioners were often part of a broader overall approach to meeting the multiple health needs of young people in the YOT.

Evidence base and rationale

Health and mental health needs

Epidemiological findings have indicated a high prevalence of complex and persistent mental health and social care needs among children and young people in contact with the youth justice system.

An estimated one third of these children and young people have mental health needs, which are often undiagnosed and untreated (Harrington & Bailey, 2006; Fazel et al, 2008). One study (Lader et al, 2000) found that eight in ten young people aged 16–20 years in custody had more than one mental health need and almost all met the criteria for a diagnosis of personality disorder.

Significantly higher levels of unmet need are found among young offenders in the community than among those in secure care, particularly with regard to education, peer and family relationships and risky behaviour (Chitsabesan et al, 2006). Female young offenders generally have higher rates of anxiety and depression and post traumatic stress disorders in particular (Chitsabesan et al, 2006). This same study also found higher rates of post-traumatic stress disorder among young people from black and minority ethnic groups. Young males tend to have higher levels of conduct disorder (Fazel et al, 2008).

One in five young people in community and custodial settings meet the criteria for a learning disability (Chitsabesan et al, 2006). Studies of young people in secure settings (Bryan, Freer & Furlong, 2007) suggest that approximately 60% have significant speech, language and communication needs. Without additional support, these young people are at high risk of educational under-attainment. Low educational achievement in school is itself a risk factor for a range of poor outcomes in adulthood, including offending behaviour, mental health problems and alcohol and drug misuse (Youth Justice Board, 2004 a).

A body of research attests to the continued vulnerability of young offenders to a range of other health inequalities into adult life, including higher incidence of physical and mental ill health, sexually-transmitted disease, injuries, and early pregnancy in females (Bardone et al, 1998; Dolan et al, 1999; Ritakallio et al, 2005). Children and young people within the criminal justice system also have very high rates of tobacco use and drug and alcohol dependence (Bardone et al, 1998; Galahad SMS Ltd, 2004, 2009), and dual diagnosis (co-morbid substance and mental health difficulties (Galahad SMS Ltd, 2007)), which are linked to significant health problems and attendant costs in adulthood. Macdonald (2006) found that many of these young people shared characteristics with other vulnerable groups such as looked after and homeless young people. Use of secondary health care services is high among this group, but use of primary healthcare service low. One study found that almost half the young people attending one YOT had no contact with a GP in the previous year (Stallard et al, 2003). Young BME people in particular are less likely to seek help from primary healthcare services for mental health problems and as a result are more likely to be admitted to secondary care services in crisis (Malek, 2004).

A range of other socio-economic factors are also associated with offending and risk of mental health problems among young offenders. These include parental criminality and drug and alcohol abuse, family conflict and breakdown, harsh or inconsistent parenting, socio-economic disadvantage and traumatic experiences, such as abuse, neglect or abandonment, resulting in attachment difficulties (Fergusson, Horwood, & Lynskey, 1994; Smith & Thornbury, 1995; Haapasalo & Hamalainen, 1996).

Mental health needs and offending

The relationship between mental health difficulties and offending is complex. Data emerging from longitudinal studies suggest that young people with conduct disorder before the age of 11 may be up to 70 times more likely to serve a custodial sentence in adult life and are more likely to be involved in violent crime (Fergusson, Horwood & Ridder, 2005), and more at risk of other, multiple adverse outcomes. These include mental illness, suicide, substance misuse, homelessness, hospitalisation and premature death, and high school drop-out rates, long-term unemployment and financial difficulties (Scott, 2008).

However, only around half of young people meeting the criteria for this diagnosis as children will in fact go on to offend and, if evidence-based parenting interventions are provided as early as possible, there is the greatest chance of avoiding this range of negative outcomes for these children (Sainsbury Centre for Mental Health, 2009a).

In the case of other mental health difficulties, the associations with offending are much less clear-cut. For example, a young person could be acting out as a result of underlying depression, or depression could result from involvement in criminal behaviour. It would be wrong, therefore, simplistically to assume that addressing mental health issues will necessarily influence offending levels. There is little evidence on the impact of poor physical health as a risk factor for offending.

That said, all services involved with children are required to promote the health and well-being of all young people (HM Government, 2004). Health and mental health inequalities and needs should be a focus for intervention, regardless of the likelihood of changing offending behaviour.

The case for early intervention

Up until 2007, the numbers of young people entering the youth justice system in England and Wales consistently rose (Department for Children, Schools and Families, 2008). Alongside this trend was a growing awareness of the multiple challenges faced by many of those entering the system. There was evidence of under-identification of mental health needs both in YOTs and in custody (Harrington & Bailey, 2006). There has been a similar failure to identify and address learning disabilities (Prison Reform Trust, 2009b), speech and language problems (Bryan, Freer & Furlong, 2007) and healthcare needs (Macdonald, 2006).

Mental health problems and emotional distress often manifest differently in younger age groups (Department of Health, 2009a). They may manifest as behavioural problems, self-destructive or high-risk behaviour or social withdrawal, which mask the underlying problems. Mental health needs can be misinterpreted as bad behaviour, or dismissed as normal adolescent acting out. There is now strong evidence that, instead of waiting until mental health difficulties reach the point of crisis, those working with young people should focus on the known risk factors for poor mental health and concentrate on promoting resilience in children and young people to prevent mental ill health and other adverse outcomes.

Longitudinal studies have consistently highlighted the importance of intervening early with young people at risk to prevent entrenched, multiple adverse outcomes, including poor mental health, suicide, substance misuse, unemployment, teenage pregnancy and offending (Champion, Goodall & Rutter, 1995; Farrington, 1994; Kazdin, 1990; Loeber & Hay, 1997; Moffit et al, 1996; Rutter, 1996, Scott, 2008). Most mental health problems in adults first become apparent during adolescence (Department of Health, 2009a). With some specific illnesses, such as psychosis and depression, an emerging evidence base shows that early intervention can reduce the impact of the disorder, improve quality of life and outcomes, and reduce use of costly hospital care in the long term (Marshall & Rathbone, 2006; Harrington & Clark, 1998).

There is now strong evidence that the most effective way to reduce both crime and poor outcomes for children is to work with families whose children are at the highest risk, at the earliest point possible, particularly where children are showing early signs of behavioural problems (Fergusson, Horwood & Ridder, 2005). Poor parenting and family dysfunction explains up to 30–40% of problematic behaviour in children (Patterson, DeBaryshe & Ramsey, 1989), indicating a need to focus predominantly on strengthening parenting skills (Scott, 2008) and on building the child's resilience (Alperstein & Raman, 2003). Parenting interventions offer the best chance of change at this early stage, with consequent reductions in crime and multiple adverse outcomes and improved life chances as these young people mature (Sainsbury Centre for Mental Health, 2009a).

Children with special educational needs and disabilities are over nine times more likely to be permanently excluded from school than the rest of the school population (Department for Children, Schools and Families, 2007), and there is an established link between school exclusion and criminal behaviour (Graham & Bowling, 1995). Identification of speech, language and communication needs and learning disabilities and difficulties at this early stage may save significant later costs by avoiding the range of poor outcomes associated with academic under-achievement.

Early intervention and diversion in the youth justice system

There will always be some children who do not respond to very early intervention or who slip through the net and end up in the youth justice system. International law states that entry into the

youth justice system should be a last resort and that custody should be used only in the minority of cases:

“Given the fact that the majority of child offenders commit only minor offences, a range of measures involving removal from criminal/juvenile justice processing and referral to alternative (social) services (ie. diversion) should be a well-established practice that can and should be used in most cases.” (UN Convention on the Rights of the Child, 2007)

There has been increasing concern and interest in the UK in finding alternatives to custody. This has been prompted in part by rising first time entry figures (partly attributed to police targets that incentivised processing as many people through the system as possible) that place the UK potentially in breach of international law. There has also been a growing awareness of the high levels of vulnerability of those entering the youth justice system, suggesting that some of these young people should be diverted along a different route (Osgood & Weichselbaum, 1984) to receive help as early as possible with mental health and other vulnerabilities and to safeguard their well-being.

Diversion offers an alternative to youth custody. Skowrya (National Center for Mental Health and Juvenile Justice, 2006) stresses that ideally diversion:

“...should occur at the earliest stages of juvenile justice processing, to refer a youth to necessary services and prevent further involvement in the system. However, diversion mechanisms can be instituted at later stages of justice processing, to prevent further penetration into the system and costly out-of-home placements.”

Evidence for the effectiveness of diversion in improving outcomes for young people with mental health and other vulnerabilities is equivocal. There are few methodologically robust studies, and none comparing the outcomes of diversion at the many different stages at which it can be used along the youth justice pathway. However, what evidence there is does indicate that diversion can reduce the risk of reoffending, promote a range of other positive outcomes and save costs across a range of public services (Sainsbury Centre, 2009b).

There is promising evidence to support the use of restorative justice as an alternative to prosecution, but only where it involves direct reparation (face to face contact), is well implemented and is well targeted (Sherman, Strang & Newbury-Birch, 2008). Restorative justice can reduce reoffending and promote accountability for offending, and is popular with those involved in the process. It also offers an opportunity to motivate young people to engage or re-engage with treatment (Sherman, Strang & Newbury-Birch, 2008), but support needs to be accessible and available.

Lord Bradley’s review of people with mental health and learning disabilities in the criminal justice system (Department of Health, 2009b) and the Healthy Children, Safer Communities strategy (Department of Health, 2009c) both emphasise the importance of identifying vulnerable children

and young people at the earliest possible stage. Lord Bradley's review also underlines the importance of commissioners taking children and young people's needs into account when expanding the criminal justice liaison and diversion teams that pick up mental health and other vulnerabilities along the criminal justice pathway.

Key messages from international research are, therefore, that:

- we need a youth justice system that actively works to improve the life chances of young people with lower level offending by means of diversion and restorative justice, so that custody is used only as a last resort
- the ideal system intervenes at the earliest possible opportunity along the youth justice pathway to identify and to support young people with mental health and other complex needs.

"A high number of cases have specific needs, despite the fact that the risks may, or may not, be seen to directly relate to the offending behaviour that has led to the community sentence." (Healthcare Commission & Her Majesty's Inspector of Prisons, 2009)

Healthcare provision in YOTs

Health practitioners were introduced into YOTs from 2000 onwards, together with a range of workers from other agencies, as a result of the Crime and Disorder Act 1998. Every Child Matters, the previous government's cross-departmental programme to improve outcomes for all children and young people (HM Government, 2004), requires all services working with children and young people to promote their health and well-being and life chances. This focus on ensuring all children are given the help they need to achieve their potential and on narrowing the gap between those children achieving the best and the worst outcomes has been reinforced in a series of subsequent reviews and policy documents (Department of Health & Department for Children, Schools and Families, 2009; Department of Health, 2009a; Department for Children, Schools and Families & the Department of Health, 2009).

In 2006, the Healthcare Commission and Her Majesty's Inspectorate of Probation (2006) found that the health practitioner role had 'drifted', due to lack of guidance at the point of implementation:

"The Government's intended role for healthcare workers in YOTs is that they would ensure that children and young people who offend had access to healthcare services. However, we found that a majority of healthcare workers spent most of their time providing services themselves." (Healthcare Commission & Her Majesty's Inspectorate of Probation, 2006)

As a result, the type and level of health care provided in YOTs was inconsistent, and in some YOTs there was no healthcare provision at all.

A follow-up review in 2009 (Healthcare Commission & Her Majesty's Inspectorate of Probation, 2009) noted continuing gaps and under-investment in health provision in YOTs. It also noted a drop in average overall spending by primary care trusts on these health practitioners (although it should be noted that the Centre for Mental Health's study found that a few of the more innovative models of YOT health provision had in fact been recorded in official records as vacant healthcare posts by mistake).

Our study was commissioned to build on the work both of the Healthcare Commission and Her Majesty's Inspectorate of Probation, and of the NACRO good practice guide for mental health workers in YOTs (2007).

Findings

Models of health provision in YOTs

The findings from this study echo those of other investigations into the role of the YOT health practitioner (CSIP & HASCAS, 2008; Healthcare Commission & Her Majesty's Inspectorate of Probation, 2009) in that we found considerable variation in how health services were being delivered in YOTs. The type and range of services offered tended to depend on the professional background and experience of the worker. The range of professional backgrounds within the teams that were visited during the study is set out in table 1. The majority of those interviewed were mental health nurses. The second most common professional discipline was clinical psychology, followed by health visiting. No national statistics were available at the time of this study on the professional backgrounds of all YOT health workers, although by the end of the study period the North West regional office was attempting to complete a national audit.

Table 1: Range of professional backgrounds in health teams visited in YOTs

	Number
Registered mental health nurses ² (RMN)	18
Community psychiatric nurses (CPN)	2
Health visitors or other nurse	5 ³
School nurse background	2
Clinical psychologists	8
Speech and language therapist	3
Art therapist	2
Learning disability nurse	2
Forensic nursing background	3
Social worker (with mental health experience or learning disability background)	1
Counsellor (with triple P parenting background)	1
Psychiatrist	3
Learning disabilities psychologist	1
CAMHS manager	3
General or children's nurse	2

² Including one CAMHS link worker

³ Two health visitors had additional forensic and mental health training.

Health team manager	1
CAMHS liaison/link post	2
Dual diagnosis worker (one voluntary sector)	2
Art therapist	2
Housing officer	1
Parenting worker/family therapist	2
Substance misuse	4
Applied/assistant psychologist	2
Total	72

The audit identified six main models of service delivery:

- the lone health practitioner model
- the foot in–foot out model
- the virtual locality health team model
- the outreach consultative model
- the internal YOT health team
- the external YOT health one-stop-shop.

Some YOT health teams adopted a combination of approaches, but most fell into one or other of these categories.

Some YOTs had no health provision at all. The reasons for this are explored later.

The lone health practitioner model

Some YOTs had recruited a single health practitioner within a one-stop-shop YOT multi-disciplinary team. Most of these lone workers had a mental health background and were seconded through arrangements with the local Child and Adolescent Mental Health Services (CAMHS). Those with a general health background had been seconded through arrangements with the local primary care trust. Some workers had links back into their seconding organisation for clinical supervision; others did not.

Advantages

We found that the health practitioner role generally attracted energetic workers, who were often ‘terrier like’ in their efforts to engage and support young people and access services on their behalf. Echoing the findings of the recent pan-London study into the YOT health practitioner role (CSIP & HASCAS, 2008), these YOTs health practitioners valued the variety and creativity of their role and gained great professional satisfaction from working with these young people who, although challenging and presenting with high levels of need, were rewarding.

It was clear that these workers were an importance resource: YOT case workers evidently valued having them on site. We witnessed YOT caseworkers on a number of occasions and in different sites seeking ad hoc advice about health issues in relation to young people on their caseloads.

Disadvantages

However, we also identified a number of disadvantages specific to this model:

- high professional and cultural isolation
- either a narrow focus, limited by the practitioner's professional training, or a tendency to 'run ragged' trying to meet all the needs of the young people referred to them. Some workers described a risk of burnout because of the breadth of need they were trying to meet and the frustration of constantly having to negotiate barriers to get young people the specialist help they needed from mainstream CAMHS
- where workers had a mental health background, physical health needs were being overlooked in some cases, and opportunities were missed to identify and address health inequalities
- a lack of clinical supervision and professional development
- poor links into local mainstream mental health and health services and lack of influence and strategic authority. We found that YOT managers and workers had a poor understanding of how strategically to achieve change in health service provision
- a risk of being drawn into core YOT work and duties, and difficulties in challenging this drift without management backing.

Foot in–foot out model

This model again usually involved a single practitioner but, to address the risk of clinical isolation, commissioners had found ways of embedding the role structurally in local health and mental health services as well as in YOTs, so they had a 'foot' in both camps. This had been done in a number of ways.

In some teams, lone health practitioners, or sometimes two, maintained links with their seconding teams and with broader CAMHS developmental issues through this 'foot in–foot out' approach. For example, in Newcastle two consultant clinical psychologists job-shared the YOT health practitioner role, spending half their week in the YOT and the other half in the specialist CAMHS team. Health practitioners talked positively about this arrangement, which they said reduced the risk of burn out' and maintained connections both with the YOT and with their CAMHS teams, thereby facilitating professional development and access to CAMHS for young people. They described the benefits of having an established credibility with the CAMHS team, which meant that colleagues trusted their judgment about referrals. They also highlighted the advantages of understanding CAMHS referral processes and criteria.

In another example, in Stockton, a YOT mental health practitioner was based in the YOS three days per week undertaking assessments, delivering interventions and referring to other relevant agencies if required. The other two working days were based in the local Child and Adolescent Mental Health Service working with a variety of young people, including those open to the YOT. This split site working ensured that the professional skills were maintained and updated. Stockton YOT health practitioners and case workers also had regular contact from a forensic child and adolescent mental health practitioner who completed outreach work into the local YOT, working with the young people and providing training, liaison and consultancy.

In Northamptonshire, two YOT health practitioners were based in a criminal justice liaison and diversion (CJLD) team, with a number of other health workers. These included a community psychiatric nurse, who assessed adults with mental health difficulties appearing in court, a resettlement health worker with responsibility for all those returning to the area from custody, and two mental health link workers working with vulnerable adults and occasionally with children who were subject to anti-social behaviour orders. These workers were based on the same corridor as the learning disability services and specialist CAMHS, which facilitated access to consultation, advice and fast track assessments in crises. The YOT health practitioners were supervised by the team leader of the CJLD team and had developed a system whereby the CJLD workers promoted the role and availability of the YOT health practitioner to the courts and the police when they contacted the team with concerns about the mental health of young people in their custody.

Other models of foot in–foot out approaches included a health practitioner in Leeds who was working half the week as part of a virtual locality YOT health team (drawing together all the lone health workers based in the area offices in Leeds) and the other half in a local secure unit as part of the CAMHS inreach and healthcare team. In her view, this foot in and out of the secure unit improved continuity of care and transfer of information for some of the young men released to her catchment area as it meant she had already established trust and a rapport with them in custody.

Advantages

Interviewees reported a number of advantages to the foot in–foot out model.

- Workers felt that it was easier to get referrals accepted because they had established good relationships and networks with CAMHS. They felt this was partly because they understood the referral criteria but also because CAMHS staff trusted their judgment. It also meant that they were able to seek consultation and get fast track assessments in crises.
- Health practitioners felt that they were kept up-to-date with changes in clinical practice and governance.
- Health practitioners felt that they could access training and professional development and maintain a critical perspective on the practices in the YOTs and on their own contribution to this work.

- In the case of the Newcastle jobshare post, the workers welcomed the case mix of young people from the YOT and from CAMHS. The YOTs referrals could be very challenging; the CAMHS cases were generally more straightforward, and so provided a welcome contrast to the complexities of the YOTs cases.

Disadvantages

No particular disadvantages to this model were raised by practitioners. However, many of those working in this 'foot in, foot out' way, were working alone in the YOT and like the lone practitioner, what health services were offered could be shaped by their professional background, rather than provision always reflecting the broader health inequalities faced by young people in YOTs. Many workers had, however, benefitted from the expertise of regional or local experts who had extended their practice in areas such as speech and communication problems or forensic health.

The virtual locality health team

The virtual locality health team model was similar to the foot in–foot out model but the workers tended to have more robust and extensive networks outside the YOT. For example, links had been made with a range of health and mental health practitioners who worked in mainstream CAMHS and other services supporting young people with similar risk factors and needs. They described working jointly with CAMHS on shared cases, linking with workers outside the YOT to allocate cases and to plan care plans, and having more robust links with a broader range of services outside the YOT. These health practitioners tended to see themselves as having a shared responsibility with health workers outside the YOT for all vulnerable young people in their locality.

One health practitioner had established good relationships with the Early Intervention in Psychosis services in the area, resulting in improved early identification and speedy joint assessment of young people in the YOT. In one instance this collaboration had resulted in the EIP team completing a court report within two weeks and recommending a package of treatment and assertive outreach support. This recommendation was accepted by the court and the young man had made good progress without reoffending.

Sheffield had developed a small, community-based forensic adolescent team that was partly based at the local YOT premises. It was led by a forensic child psychiatrist and a forensic psychologist. The forensic team split their work between the YOT (60%), a local secure children's home (20%) and young people in local authority care (20%). The team included two YOT health practitioners who, because of the support available from their forensic colleagues for more complex cases, were able to cover preventative and pre-court work. This was a rare example in our study of a preventative focus.

Bradford YOT had a team of health practitioners based with them but also had good links and shared working arrangements with CAMHS and health colleagues in the locality. The team mainly comprised school nurses (one of whom was the team co-ordinator) but also included a general nurse with experience of working in a secure unit. This team had been set up specifically to link young people into mainstream services, not to meet their needs within the YOT.

Fortnightly referral and allocation meetings were also held with a local psychiatrist, a community psychiatric nurse from CAMHS, the named nurse for safeguarding children, and a local substance misuse specialist to consider referrals for young people with mental health needs, and to provide advice. The psychiatrist would also prepare some court reports.

The YOT team was also part of a virtual safeguarding health team in the area that brought together nurses and health representatives to focus on domestic violence, looked after children, teenage pregnancy, accident and emergency admissions and social care teams. The named safeguarding nurse for children led this team and provided supervision to the YOT health practitioners. The safeguarding health team also produced reports for commissioners and for the local safeguarding and YOT management board.

Every Child Matters targeting framework (HM Government, 2004)

Universal services work with all children and young people. They promote and support mental health and psychological well-being through the environment they create and the relationships they have with children and young people. They include early years providers and settings such as childminders and nurseries, schools, colleges, youth services and primary health care services such as GPs, midwives and health visitors.

Targeted services are engaged to work with children and young people who have specific needs – for example, learning difficulties or disabilities, school attendance problems, family difficulties, physical illness or behaviour difficulties. This group of services also includes CAMHS delivered to targeted groups of children, such as those in care.

Specialist services work with children and young people with complex, severe and/or persistent needs, reflecting the needs rather than necessarily the ‘specialist’ skills required to meet those needs. This includes CAMHS at Tiers 3 and 4 (although there is overlap here as some Tier 3 services could also be included in the ‘targeted’ category). It also includes services across education, social care and youth offending that work with children and young people with the highest levels of need – for example, in pupil referral units (PRUs), special schools, children’s homes, intensive foster care and other residential or secure settings.

The CAMHS four-tier system

The Child and Adolescent Mental Health Services (CAMHS) four tier system provides a structure for delivering the different levels of service response to children and young people's mental health needs. The tier system is still in use but has since been superseded by the Every Child Matters targeting framework.

Tier 1 – Services provided by practitioners working in universal services (such as GPs, health visitors, teachers and youth workers) who are not necessarily mental health specialists. They offer general advice and treatment for less severe problems, promote mental health, aid early identification of problems and refer to more specialist services.

Tier 2 – Services provided by CAMHS specialists working in community and primary care settings (such as primary mental health workers, psychologists and paediatric clinics). They offer consultation to families and other practitioners, outreach to identify severe/complex needs, and assessments and training to practitioners at Tier 1 to support service delivery.

Tier 3 – Specialist CAMHS services, usually provided by a multi-disciplinary team or service working in a community mental health clinic, child psychiatry outpatient service or community setting. They offer a specialised service for children and young people with more severe, complex and persistent disorders.

Tier 4 – Specialist services for children and young people with the most serious mental health and behavioural problems. These include day units, highly specialised outpatient teams and inpatient units, which usually serve more than one area.

In Hackney YOT, strong links had been formed with the local Teenage Health Demonstration Site (THDS), which worked with the health practitioners to support young people into local services and address needs.

Advantages

YOT case workers and health practitioners were generally very positive about this type of model. The advantages were described as:

- a feeling of shared ownership of vulnerable young people with other workers working with similar client groups. In Bradford, this shared ownership also seemed to have led to improved strategic co-ordination of services, with workers able to see the links between their areas of work and provide useful feedback on needs to commissioners

- having two virtual teams with strong links to other community health provision for vulnerable children and young people had helped young people in YOT to access services outside the youth justice system, reducing the risk of getting stuck in silos
- the Bradford model had helped the health practitioners access good quality supervision, peer support and professional development
- health practitioners received consultation, support and advice from specialist and forensic CAMHS in two of these models, which enhanced their skills and confidence in working with these young people
- some cover could be provided by the wider team during periods of annual leave
- in Sheffield, close links between the YOT, the psychiatrist and the secure children's home had helped with continuity of care when the young person returned to the local community.

Disadvantages

Some localities reported gaps in provision, but this reflected a need for improved commissioning rather than any drawbacks to the model. For example, Bradford had limited availability of CAMHS services for young people aged 16–18 years and no access to forensic mental health services or consultation. No other specific disadvantages were associated with this model. It was generally thought to be an improvement on what had previously been provided within YOTs.

Outreach Consultative team model

In a small number of areas a model had been established to provide support in a rural area or on a regional basis for health practitioners in YOTs.

In Northumberland, for example, lone health practitioners in rural YOTs worked closely with and received supervision from a CAMHS outreach team, called the Northumberland Young People's Service, specifically commissioned for vulnerable young people. After screening young people for general health and mental health needs, the health practitioner would check that young people were registered with GPs. She would also deal with general health and sexual health needs and deliver lower threshold mental health support (such as anger management sessions or brief interventions). Those with multiple or complex needs were referred to the CAMHS outreach team for assessment and intervention. When very specialist needs were identified (for example, management of young people with sexually harmful behaviour or other potentially high risk behaviours), the health practitioner referred the young person to the community forensic mental health team in Newcastle or to an Early Intervention NSPCC scheme for those with sexually harmful behaviours. In all cases, these higher tier services provided consultation and sometimes worked jointly with the health practitioner.

An engaging model for vulnerable young people in a rural community Northumberland young people's service (NYPS)

This team had been jointly commissioned from pooled Local Authority, Drug Action Team and Primary Care Trust funding and covered a rural area. It focused on the multiple needs of vulnerable children and young people including Looked After Children, young people with substance misuse difficulties and those with mental health difficulties at risk of offending. The team consisted of a clinical lead (community psychiatric nurse) and two further full time community psychiatric nurses plus part time admin support. Access to the service was guaranteed within 13 days. Referrals were not turned away, although some advice might be offered to referring agencies about alternative appropriate care pathways. This 'no refusal' approach had been agreed to minimise the chances of young people and their families falling into the gaps between services. The team saw young people at home, in parks, in coffee shops, wherever they chose, and engagement was seen as the highest priority. There was an emphasis on working closely with families and extended carers and the team very much focused on the young person in the context of the systems around them. The team saw approximately 100–110 new cases per annum and worked very intensively with a small number of the young people on their caseload. The service was based on the philosophy of a holistic approach to care. This involved not just individual therapeutic sessions with young people but a comprehensive support framework for parents, carers, and other professionals such as YOT health workers, teachers and other staff from the commissioning services. They offered phone consultation to all YOTs in the area and also provided supervision for some YOT health practitioners. The effectiveness of care is therefore founded on the establishment of sound multi-agency partnerships. Staff worked closely with CAMHS learning disability teams locally and often completed joint working.

In Islington, the Youth Offending Service and targeted youth services in the borough have recently merged strategically. The former CAMHS-YOS team was unusual in this study in that it supported the work of both targeted youth workers and voluntary sector preventative services in the area as well as supporting those working in the YOT. The team included a clinical manager, a youth counsellor, a trainee clinical psychologist, a family therapist clinical nurse therapist, a dual diagnosis drug and alcohol worker, and a sexual health and relationships worker. The health team has adopted an 'outreach consultative' approach which meant that rather than expecting the young person to be referred on to them as health specialists, they instead skilled up those working directly with the young people. This was achieved through some joint working and problem solving (both with the worker and the young person), as well as through regular consultation and supervision with the outreach worker to support the young person's progress.

This model of working is based on the Anna Freud Centre's Adolescent Mentalisation-Based Integrated Therapy (AMBIT) approach which is designed for traditionally hard to reach young

people with complex and multiple problems, particularly those who are in psychiatric crisis. Its aim is to extend and sustain the skills of frontline outreach workers best placed to engage with these young people. The approach is also believed to minimize the risk of service duplication. It also works well when young people have a range of complex issues and risk getting passed from specialist to specialist, when they are nervous of mental health services or substance misuse services, or where services are poorly designed to engage them.

In Islington, the Targeted Youth Support and Integrated Health Team work closely with Family Intervention Project teams, with the voluntary sector and support local gang-related prevention work, skilling up these frontline workers as described.

In Staffordshire YOT health practitioners (one with a mental health background, one with and learning disability background and one with a children's nurse background) were supported by and worked jointly with a mental health team specifically commissioned to work with young people who offend called Engage. Like the Northumberland model, this team had a no refusal approach to referrals. The health practitioners have a two weekly meeting with the Engage team to talk through referrals and for consultation. Engage also offer consultation to YOT case managers.

In the Thames Valley area, the YOT health practitioners were supported by regionally commissioned forensic mental health child and adolescent services. The consultant psychiatrist who headed this team liaised regularly with YOT health practitioners on the management of complex cases, provided consultation, training and supervision, and wrote court reports and provided consultation and advice on what should be said to the court in specific cases. The forensic team also provided inreach mental health services to a local young offender institution and training to police, magistrates, CAMHS and YOT health practitioners.

Advantages

Health practitioners in these areas said that they valued:

- the easy access to expertise and support that these models provided for young people in YOTs (often via telephone contact). This meant that health practitioners and YOT case managers without mental health expertise and in both rural and urban areas could be skilled up and supported with the day-to-day management of young people with mental health difficulties and complex needs
- the speed of access to assessment for young people presenting with complex needs and risks
- the support this model offered to isolated workers in rural settings
- the no refusal approach of some of these models
- in the case of the north east model, the approach of this particular service, which was felt to maximise the chances of young people engaging with services.

Disadvantages

The only real disadvantage identified for this approach was the lack of sustainable funding for some schemes.

The external YOT health one-stop-shop

In one county commissioners had not funded mental health practitioners in the YOT. Instead an innovative and very engaging specialist resource called Head 2 Head had been established.

Head 2 Head, Nottinghamshire

Head 2 Head works with children and young people with:

- sadness and unhappiness, low mood and depression
- self-harm eg cutting, taking overdoses, or engaging in other harmful or risky behaviour
- communication problems
- flashbacks that are having a negative impact on their life
- sleeping or eating problems
- emotional problems due to past abuse
- hearing voices, hallucinations, feeling very paranoid
- drug or alcohol issues that impact on their mental health and well-being
- angry feelings and impulsiveness
- family problems such as conflict or linked to parental mental health.

Head 2 Head is a Tier-3 mental health team commissioned jointly by the PCT, the local authority and the Drug Action Team to meet the needs of all young people with complex needs across the region. They include young people with substance misuse and mental health needs, looked after children, young offenders and those at risk of sexually harmful behaviours. The team contacts all young people who are referred from the YOT by letter and uses an outreach approach, meeting young people wherever they feel comfortable (eg. at home, school, college, work, GP surgery, health centre, court, YOT office). The service is staffed seven days a week by a team of 15 full-time workers. Most team members are mental health nurses but the team also includes one learning disability nurse, a social worker and sessional time from a psychiatrist with specialist skills in dual diagnosis work (0.5). The team also provide some consultation to YOT workers but was reported to have less systematic physical presence in the YOTs (either for discussion of cases or to provide supervision for staff) compared with those working in a consultative outreach manner.

Advantages

This model was perceived to offer several advantages:

- access to a breadth of expertise able to address a wide range of needs, including coexisting vulnerabilities, family work etc
- speedier responses to referral and initial assessment in comparison with other Tier-3 CAMHS
- the Head 2 Head team had a very engaging and young person-friendly approach
- a wide choice of workers available on the team
- seven-day cover
- the team was linked into other local community mental health and children's services rather than being isolated within the YOT.

Disadvantages

Although the team was considered very innovative and engaging in its approach with vulnerable young people, there were mixed views about how well this arrangement suited YOT caseworkers' needs. Some teams in the area very much valued the resource; in others the lack of a health practitioner presence within the YOT, in particular for informal discussion of cases, was seen as a downside. It was also pointed out that the same innovative approach was not available for young people with other, physical health needs in the youth justice system in the area.

The health team within a YOT

There were examples in areas such as Salford and Lewisham of health teams developing within the YOT. In Lewisham, the ARTS forensic team was located in the YOT itself and included a wide range of health staff:

- a clinical psychologist
- team manager – social work background
- two mental health substance misuse nurses
- a consultant psychiatrist (two sessions a week)
- an administrator (half time)
- a mental health liaison and diversion worker for young people.

All but one post was funded through the South London and Maudsley NHS Foundation Trust (SLAM). The diversion worker had been employed with short-term Department of Health funding. Cases were generally managed directly by the ARTS forensic team, although some referrals were made to other services. There were good links between the clinical managers in the ARTS team and the local CAMHS. One mainstream CAMHS manager had oversight and input into the diversion and liaison pilot project.

Lewisham ARTS Forensic Team

The team provided the following range of services:

- **Mental Health Assessment**, including –
 - forensic psychiatric assessment, risk management
 - other specialist mental health assessment using various psychological tools, i.e. PCL-YV, MACI, WISC-I
 - specialist assessment of sexually harmful or violent behaviours
- **Prescribing**
- **CPA care co-ordination**
- **Mental health interventions** including –
 - CBT
 - psychotherapy
 - family and parenting support
 - anger management programmes
 - AIM programme for sexually harmful behaviours
- **Tier 3 substance misuse interventions**, including –
 - motivational interviewing
 - solution focused therapy
 - harm reduction
 - cannabis reduction programme,
 - safer injecting practices and Blood Borne Viruses service
- **Consultation and training** to networks of professionals on young people displaying a wide range of harmful, high risk behaviours including sexually inappropriate behaviour
- **Liaison with Young Offender Institutes**, including passing on issues related to risk of self-harm and risk to others.

Salford YOT had also established a small health team within the YOT. The team comprised:

- a deputy manager of the YOT (formerly a health practitioner and school nurse) who was YOT funded but also provided some clinical supervision
- a general nurse (PCT funded/seconded)
- a speech and language therapist available three days a week (YOT funded)
- a CAMHS liaison/consultation worker available for one day a week

- a clinical psychologist 2.5 days per week (CAMHS funded/seconded)
- a substance misuse worker (YOT funded)
- a parenting worker (YOT funded).

The team also included a YOT funded resettlement worker who provided voluntary advocacy and wraparound help for young people with Tier-3 substance misuse and multiple needs.

The speech and language worker provided consultation and training for YOT case workers, schools, parents and magistrates. The team had used the speech and language service most frequently for young people at risk of exclusion from school, resulting in positive behavioural change.

Advantages

YOT caseworkers and managers were very positive about these internal health teams. Co-location was said to improve joint working with YOT caseworkers, and regular consultation took place with in-house mental health specialists.

Other advantages included:

- there were no waiting lists for assessments
- the team understood the need to address risk factors for poor mental health, the impact of multiple needs on young people's well-being and the need for early intervention in response to signs of poor mental health. Young people who needed specialist and targeted support could be served within the same team (in other areas some YOT health practitioners had described young people being batted to and fro between services)
- there were good opportunities for shared clinical learning and professional development through having a consultant psychiatrist and a clinical psychologist on site
- a broad range of skills was available on site.

Disadvantages

Some disadvantages were noted. In the case of one of these teams, although mental health had been well resourced by commissioners, the same attention was not given to the other health needs of the young people. In addition, because these services were based on site, there was a risk of the young people remaining in YOT 'silos', and not being helped to make use of the full range of mainstream community services, as recommended by Healthy Children, Safer Communities (Department of Health, 2009c). There was also a risk that, without careful planning and vigilance, staff in the teams could become isolated from developments in mainstream services and from lower level universal provision for children and young people and their families.

Keeping in touch with the full and developing network of children's services in a locality was reported to be a challenge for all workers, but arguably presents a greater challenge for those working in very specialist services or providing services across a region.

YOT teams with no recorded health input

When our study began, 17 of the 157 YOTs in England and Wales were recorded as having no health practitioner in post. Information on the number of health practitioners in post was collated by the Youth Justice Board between 2005 and 2006. However, on investigation, we found that these apparent gaps in provision were not always what they seemed.

For example, in Nottinghamshire YOT teams did not have a health practitioner located in the YOT (as described above); instead they used a specialist CAMHS team commissioned specifically to meet the needs of young people in the youth justice system. In Lewisham, where again the records showed there was no health practitioner post, the South London and Maudsley NHS Foundation Trust (SLAM) had commissioned a mental health team within the YOT team to work with young people who were in contact with the local youth justice service.

Another vacancy had been identified in a rural area in Wales but further investigation revealed that a specialist CAMHS worker was providing regular 'foot in-foot out' cover to three YOT teams, spending a day a week with each team. The YOT manager had also established good links with the local community nursing team who took referrals and provided support regularly to YOT clients. Although the YOT manager felt that there was scope for more proactive work to meet the full extent of health needs among the YOT caseload, the same argument was often put forward by teams who had a lone health practitioner on site.

In a small number of cases, therefore, it appeared that there was some misinformation in the national data collection.

Where vacancies were accurately recorded, the following reasons were given to explain the lack of health practitioner input.

- **Recruitment problems** – YOTs and commissioners reported that it was often difficult to find CAMHS and health workers locally who wanted to work in YOTs. The reasons for this included nervousness about working with the client group, concern about professional isolation, and lack of opportunities for career progression.
- **Lack of contingency arrangements** – Some reported vacancies related to long-term sickness or maternity leave: no contingency arrangements had been built into service level agreements to manage such vacancies. The most recent Healthcare Commission and HMIP (2009) report found that many YOTs and PCTs/health trusts still do not have a service level agreement in place for employment of YOT health practitioners.
- **Lack of exit planning for health practitioners** – Many health practitioners were seconded into posts from local CAMHS. In some areas, when the health practitioner returned to their

seconding team, significant delays could occur in recruiting a replacement. Sometimes vacancies could not be filled for over six months.

Our study did pick up longer term vacancies in some YOTs. These had occurred for a variety of reasons:

- changes in commissioning boundaries, creating a gap in commissioning that had taken time to resolve.
- a two-year gap due to 'a lack of interest and commitment' from the specialist CAMHS (and no appetite in the locality to challenge this)
- a seconded health worker post was withdrawn when the PCT decided to provide support via the local specialist CAMHS team instead. However, access to this service was reported as poor and the YOT was dissatisfied with replacement arrangements.

In this last case, a needs assessment had been completed in the area for local YOTs and for a local young offender institution (for those under 18 years of age) in an attempt to drive developments forward. The findings confirmed the significant and complex needs of young people who offend and joint commissioners and service leads were trying to reach agreement on how to meet these needs. However, the process had been very longwinded and complicated, leaving longstanding gaps in service in both the secure estate and in local YOTs.

Summary of findings

Although the extent of the health and mental health needs of young people in the youth justice system is well documented, our study found highly variable models and provision of healthcare in YOTs. These variations appeared to result from:

- a lack of overarching guidance for practitioners and commissioners about the healthcare functions and resources required to meet the well-documented needs of young people in YOTs, the pathways for meeting these needs in the locality (including protocols to support referrals) and the range of competencies available to the YOT to ensure that needs are swiftly met. This lack of clarity (together with variations in local support services) has led to different interpretations of what should be in place and how services should be delivered
- recruitment of workers with different professional backgrounds
- differences in the extent to which commissioners wished to integrate YOT work within broader strategic provision for vulnerable children. Our study found different views about whether these young people's health needs should be supported within YOTs or referred out to and 'owned' by mainstream services outside YOTs
- differences in YOT managers' understanding of how health services and local and national commissioning worked and the levers necessary for influencing broader local strategy to ensure that the needs of the young people and staff were promoted
- different levels of awareness and concern about the professional isolation of health workers in YOTs

- varying levels of financial investment by the PCT and mental health trusts. Some of the models received/required much higher levels of investment than others. The reasons for these discrepancies in spending were attributed by interviewees to a range of factors such as a lack of knowledge, low prioritisation or lack of interest on the part of commissioners about the needs of young people in the youth justice system. In some areas, additional financial investment had been secured through the efforts of frontline workers
- variable extent of ownership of these young people by mainstream services. Some health teams had made positive efforts to link into and out of the YOTs by forming local networks with mainstream services such as safeguarding nurses, looked-after children's nurses and CAMHS teams working with vulnerable young people. In other areas YOT practitioners reported pressures to keep young people within the YOTs: one worker said that she had specifically been told to keep young people away from mainstream mental health services
- failure to undertake thorough needs assessments to inform commissioning decisions
- the need to develop specific models for rural populations
- variable capacity among local mental health and health services to free up workers for YOTs
- variable levels of awareness about the importance of professional development and support for isolated YOT healthcare practitioners, and the need for mechanisms to redress professional isolation and improve links to external health teams
- where health input was commissioned regionally, failure by some of the PCTs involved to buy into the whole regional package linking YOTS and secure units.

Contrary to the original intention for the health practitioner role, many of the workers interviewed in this study had ended up delivering healthcare directly to young people, instead of supporting them to access mainstream local services. The reasons for this appeared complex and included:

- a belief that a 'referral only' approach was professionally unsatisfying and restrictive
- difficulties accessing other services – when young people were refused access to these services, health practitioners described taking pragmatic decisions to support the young person directly themselves
- a need to fill gaps in services available locally for young people (for example, anger management interventions, dialectical behavioural therapy)
- ethical concerns about jeopardising the young person's progress by passing them on to others just as they had begun to build a relationship and develop familiarity and trust with staff.

Summary of learning points from the YOT models of health provision identified in this study

The following learning points are suggested from the different models of health provision which we identified during this study.

Health practitioners working alone needed support:

- As well as receiving operational management within the YOT, health practitioners on their own in YOTs need good quality systematic operational and clinical links with a designated mainstream health or mental health team (ideally with a similar focus on vulnerable young people). This will mean attending these teams on a regular basis to attend training, clinical supervision, and team development opportunities. Ideally health workers should be linked with others with a focus on vulnerable young people.
- As indicated earlier, YOT health practitioners need to be supported by a clear set of care pathways with fast track arrangements for specialist assessment negotiated and clarified and a procedure for troubleshooting if children and young people are bounced back from specialist services and risk falling between the cracks of services. This will be even more important when workers are functioning alone in YOTs.
- Some YOT physical health practitioners had benefitted from creating local networks or virtual teams with other practitioners such as Looked After Children nurses and Safeguarding nurses, school nurses, although some of these resources are more readily available in urban areas. Some practitioners in rural areas have created virtual teams linking up with specialist mental health teams for vulnerable young people or with forensic services serving their local area or region.
- Most importantly, health practitioners in YOTs benefit from having access to pragmatic expert consultation from a range of specialists (but particularly those with knowledge of health inequality work, sexually harmful behaviours, paediatrics, forensic mental health, dependent substance use, Looked After Children's needs, speech and language problems, learning disabilities etc) to support the multiple and sometimes complex needs of young people in the YJS. For example, in some local areas systematic 'outreach' consultation offered by specialists had extended the skills and professional development of YOT health practitioners, YOT case workers and CAMH workers. In this way, specialist services were able to spread resources further and facilitate effective therapeutic outreach work by frontline workers to young people in contact with YOTs. It means that young people do not have to be referred and passed on to specialists and meet new workers, particularly in circumstances where they are nervous of accessing mental health services. There were examples of consultative approaches working in both urban and rural settings. One consultative approach was commissioned on a regional basis to make the service more cost effective. Where these consultative services had been regionally commissioned it also appeared to improve the consistency of what was being provided from YOT to YOT and in some cases, between secure settings and YOTs.
- When health teams are located outside the YOT, there is still a need for staff providing this health service to make regular systematic visits to the YOT to consult with YOT case managers and to talk through problems with accessing services and meeting need.
- Where YOTs have an integrated health team (including physical health, mental health, speech and language workers, substance misuse workers etc) commissioned in the YOT itself, it is still important for workers to forge systematic links with the broad range of

voluntary and statutory services outside the organisation to ensure that YOTs do not become isolated from mainstream services. The importance of voluntary provision for young people who are nervous of mental health services or who have mild to moderate learning disabilities has been highlighted during the course of this audit.

Key challenges for YOTs in securing adequate and consistent health provision

This section explores some of the main barriers to obtaining adequate and consistent health care provision reported by interviewees in this study.

Commissioning

The study identified two main patterns of commissioning: commissioning that was driven primarily from the bottom up by frontline workers and managers, and commissioning that adopted a more top down approach. By the end of this study, a number of areas were moving towards developing regional commissioning strategies driven by regional leads.

Bottom up commissioning

Bottom up commissioning was evident in areas where interviewees had been involved in the initial development of the YOT health service in their locality and then, for a range of reasons, found themselves continuing this commissioning role. For example, a manager who started as a YOT health practitioner explained that no one knew what the job entailed when the project started and so she had been instructed to 'do whatever you want'. As a result she had been centrally involved in shaping what was provided and negotiating funding with commissioners. She secured £100,000 in grants for parenting and substance misuse input. Later she was successful in securing four-year funding for a sexual health worker in one area. There had been increasing involvement from the CAMHS commissioner over the years, who had helped develop the service level agreements to clarify what the health service should provide, and also sat on the YOT management board as well as the local CAMHS partnership board.

However, other health team managers described continuing to hold significant responsibility for commissioning and ascribed this to local commissioners' lack of confidence and knowledge about young offenders with multiple needs.

In East Sussex the YOT manager was given the funds directly to commission what was provided. In Bradford commissioning had also been influenced initially by the YOT manager, who was described as 'doggedly' seeking out additional funding. The levels and range of services were also shaped by the availability, interest and commitment of local 'champions' for the YOT client group (eg. a psychiatrist with an interest in developing services for vulnerable young people). The potential downside of this kind of localised commissioning was that it led to considerable variation between YOTs and relied on committed and knowledgeable individual champions, who might move on to other posts.

Top down and regional commissioning

Some areas reported a more strategic and regional approach, in line with Department of Health World Class Commissioning guidance (Department of Health, 2007) and supported by the Department of Health national adviser for the commissioning of mental health services for children in secure settings. Needs assessments had been carried out, followed by detailed discussions with providers and stakeholders to improve and develop what was commissioned. In some areas, focus groups had been conducted with young people to inform the development of a regional framework.

By 2010, this approach had resulted in a number of gains. In one area, a very experienced CAMHS manager in a local secure unit had been commissioned to provide supervision to YOT health practitioners to improve the quality and consistency of the service and support continuity of care. The original aim had been to include all secure units in the area under one governance structure. However, negotiations had ended without full agreement by all parties.

The same barriers to progress were cited by a CAMHS manager in another region. In this area a commissioning framework had been produced by the regional office. A detailed mapping exercise had been conducted of all services with the potential to support young people on their journey through the youth justice system, from point of entry to point of resettlement post-custody. A set of quality indicators had also been produced for all those working with young people in and at risk of entering the youth justice system in the region. The aim was to pull all provision in the region under one umbrella in order to improve consistency, ensure access to other experts for the YOTs practitioners, and improve outcomes for young people. The CAMHS manager explained that, despite these efforts, getting consensus on and commitment to translate the framework into practice was proving a challenge. She felt there was a lack of commitment from some quarters because there was no direct incentive, through targets, inspections or national directives, to take the work forward.

In yet another area, a regional YOT manager described as a 'major headache' attempts to develop services regionally to improve the health input available in the secure estate and in local YOTS, because of the 'unclear relationship between local authority children's services and health commissioning'. Negotiations with stakeholders had continued over three years without resolution, resulting in one area having no health input to YOTs at all.

Evidence of service level agreements with partner organisations was mixed: some YOTs had them, some did not, and some interviewees didn't know if they did or not.

The YOT Management Board

There were mixed reports by health practitioners on the contribution made by YOT management boards to frontline work. Most areas visited had a health representative on the board, although

there was a lack of clarity about regularity of attendance in some areas. Some health workers said that they regularly fed into the management board to inform the work programme.

This study highlighted the need for a proactive and knowledgeable PCT representative on the YOT management board to highlight the therapeutic and health inequality needs of young people in YOTs, to troubleshoot service delivery problems, to feedback to local and regional commissioners and most importantly to drive forward the development of care pathways identified as important to supporting health practitioner work. The Youth Justice Board are currently reviewing the function of YOT management Boards

Supporting needs across the entire youth justice pathway

The Bradley Report reinforced the importance of early intervention and joint working between health and criminal justice agencies along the entire criminal justice pathway (Department of Health, 2009b). Healthy Children, Safer Communities (Department of Health, 2009c) also stressed the need for early identification and support for young people at high risk of poor mental health or mental health difficulties, learning disabilities, speech and communication problems and other safeguarding concerns. Evidence-based early interventions can reduce long-term costs and maximise opportunities to reduce reoffending (Sainsbury Centre for Mental Health, 2009a), as well as reduce the risk of poor long-term outcomes (Marshall & Rathbone, 2006; Sainsbury Centre for Mental Health, 2009a).

Preventive health input in YOTs

We asked YOT health practitioners where the majority of their work was focused along the youth justice pathway. Only two teams we visited reported having systematic arrangements in place to address health and mental health needs at the preventative stage, although a small number reported that they took on this work if significant concerns were identified.

Health practitioners also said that they found it difficult to access specialist support when they identified mental health concerns. Many said they had insufficient health resources to cover the entire youth justice pathway.

“Since the relevant legislation is nearly ten years old, we might expect to see that health workers and health services contribute well to packages of support for people on bail and the pre-sentence reports (PSRs) offered to courts. We might also expect courts to be well aware of health services offered in their area and how this might contribute to the reduction of offending behaviour. At the very least, we would expect to see relevant health information being considered during the sentencing process. This was disappointingly not the case in too many areas.

“Just over half of PSRs had health information included.” (Healthcare Commission & HMIP, 2009)

Point of arrest work

Four out of 65 health practitioners said they intervened ad hoc at the point of arrest or at the pre-court stage where reprimands and final warnings are made. Two sites had a more formal process in place and used a multidisciplinary adult mentally disordered offenders' panel to pick up young people about whom there were significant concerns. These young people were usually identified by Appropriate Adults or by the police. However, the health practitioners in both sites had concerns about the adult focus and approach of this panel.

The lack of health input at this early stage of the youth justice pathway is concerning. The police are good at identifying people with severe mental health problems but they are less proficient at spotting more subtle signs or hidden disabilities, such as speech and communication problems and mild to moderate learning disabilities (Prison Reform Trust, 2009b; Sainsbury Centre for Mental Health, 2009b), which are more common in children. The Prison Reform Trust suggests that lack of attention to these issues at the point of arrest, during police interviews and at the point of prosecution may jeopardise the fairness and effectiveness of the criminal justice process as young people may misunderstand what they are told and so make poorly-informed decision and agreements (Prison Reform Trust, 2009b).

In Milton Keynes YOT all young people on statutory orders are screened for speech, language, communication and learning difficulties as well as disabilities when they start a statutory order. In addition, systematic screening also takes place of anyone who has previously not been screened and:

- who is at risk of custody/remand
- who is in breach
- who has re-offended on an order who has struggled to keep appointments for court reports

A combination of tools are used including an adaptation of the Hidden Disabilities Tool (HDQ) currently being adapted and piloted by the Communication Trust for children and young people

A care pathway has been developed with local speech and language therapists and with the local learning disability team. Screening can result in no further action, advice and consultation for the YOT case manager, further assessment, and specialist intervention and support.

Tentative findings from this screening suggest that young people with the highest risk of re-offending had the most severe speech and communication needs (worse than 98% of the population) as measured through these tools. Furthermore, all of those identified with these higher level needs were unaware of having any speech and communication impairment even when it had significantly affected engagement at school, opportunities and general progress.

Discussions with the Crown Prosecution Service (CPS) during the course of this study also indicated that many of the warning 'flags' in the paperwork that are commonly used to identify people who may have mental health and/or mental capacity issues (such as a record of the presence of an

Appropriate Adult in the police interview) cannot be used with children as all young people should have an Appropriate Adult in attendance in police and court interviews. The CPS has acknowledged the need for better quality information and a draft template for exchange of information between health workers and the CPS is currently being piloted in six sites.

Two YOT health practitioners had negotiated with local criminal justice liaison and diversion (CJLD) schemes for adults, to alert them if there were any significant concerns about the mental health or capacity of a young person in the police cells or in the court. The health practitioners involved in this partnership thought that this scheme worked well for young people with severe mental health problems. A recent NACRO study (2009) had identified a very small number of adult CJLD schemes that also dealt with young people aged under 18. However, when we contacted them by telephone, most said that they did not, in fact, provide a service for under-18s. One adult CJLD worker said that he would see young people if the courts or police were worried about them but did not feel that the service he provided was sufficiently proactive to match the level of need.

It was also said to be unusual for health or mental health needs to be identified or focused on in a structured way at the point of remand into custody. The Centre has estimated that diversion from remand of people with mental health needs can save considerable costs (Sainsbury Centre for Mental Health, 2009b). The Prison Reform Trust investigated use of remand with children and young people and identified greater scope for systematic screening and support for mental health needs in courts and in police stations (Prison Reform Trust, 2009a).

“We are trying to get it so that they should really ask for an assessment by me before they order a psychiatric report, because they cost so much money...We’d only really ask for a psychiatric report if it can’t be dealt with locally. For example, if I can nip into CAMHS and get someone to do it, then the courts are happy with this and don’t want a full adjournment.”
(Mental health practitioner, YOT team)

“In general, packages of support for people on bail that involve health interventions were very rarely used and, although ‘stand-down’ reports were used to speed up the court sentencing process, there was usually no time, or opportunity, to find out about health needs.”
(Healthcare Commission & HMIP, 2009)

Court work

An equally small number of YOT health worker interviewees provided a service to the courts.





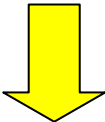
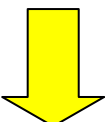
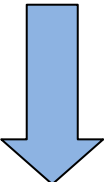

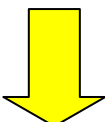
A small number of teams who had established good working relationships with sentencers and court clerks (through training or presence in courts, via proactive and well informed court duty officers or through partnerships with adult criminal justice liaison and diversion schemes) were sometimes called on to assist sentencers. In the Thames Valley area, a forensic mental health consultant psychiatrist would support health practitioners across the region to provide advice to magistrates when dealing with young people with mental health or other complex issues. This consultant psychiatrist also provided regular training for the police, CAMHS, sentencers and the YOT to improve identification and referral rates. In Northamptonshire the health practitioner was sometimes called into court or provided written advice and updates to magistrates about young people needing further psychiatric or psychological assessment, their progress, the type of report required and the key areas the report should cover. In Lewisham the court had occasionally sought advice from the ARTS mental health team (see above) as to whether cases came within the remit of mental health legislation or the Children Act. Islington and York YOT health workers reported that they routinely attended the Youth Court to provide support for young people, their families and court staff.

It was much more common for YOT health practitioners to have contributed to pre-sentence reports but this had usually been at the instigation of the person writing the report (if they had concerns about the young person's health or mental health) or because the young person was on the health practitioner's caseload. Reliance on referrals from YOT caseworker colleagues was not effective; some health workers who had completed caseload audits reported under-identification of health needs. The Healthcare Commission and Her Majesty's Inspectorate of Probation (2009) recommended systematic improvement in the amount, regularity and quality of health information included in pre-sentence reports.

Psychiatric reports and youth courts

Courts had different procedures for arranging psychiatric reports and updates on young people in contact with CAMHS services. Arrangements also varied between PCTs. In one region, CAMHS specialists routinely wrote updates for court on all children and young people who were or had been on their caseload. In other areas only those specifically contracted by the PCT to prepare psychiatric reports were able to do so. There was disagreement between CAMHS professionals interviewed in this study about whether it was appropriate to write court reports. One health practitioner wrote informal reports to update the court on a young person's progress or to advise about whether a fuller report was needed and/or the type of report required (mirroring the activity of adult criminal justice diversion and liaison schemes).

Table 2: Where most YOT health practitioner activity was focused along the youth justice pathway

Very little activity	Very little activity	Very little activity	Very little activity	Some activity	Some activity	Most activity	Very little activity	Some activity
								
Preventative work or police community referrals.	Police custody	Pre-court	Bail and remand liaison	Court duty liaison	PSR assessment and liaison (not often at referral order stage)	Sentencing packages and support	Through-care	Resettlement

Other CAMHS mental health practitioners, psychiatrists and managers questioned the appropriateness of YOT health practitioners writing reports for courts and argued that they were insufficiently qualified and/or were open to legal challenge. However discussions with workers in adult court mental health teams suggested that this was not a major concern for them. For example, Bristol was piloting a system whereby mental health nurses would write regular reports for the courts on defendants' health and mental health status before plea, contribute to pre-sentence reports for courts, co-ordinate health input to packages of care, advise when a full psychiatric report was required and liaise with psychiatrists to ensure all information was available, that proposals were workable and agreed by local services and that the report writer was aware of the court's specific areas of concern.

A number of difficulties were noted by interviewees in relation to the provision of psychiatric reports:

- psychiatric reports could not be ordered until after pleas had been entered, which meant that they were routinely ordered very late in the youth justice process; needs were also often left unaddressed until this very late stage

- psychiatric reports took a long time to prepare, ranging from two weeks to many months in very complex cases
- although defence solicitors could order reports at an early stage, we were told that there was an incentive, even in cases with clearly visible needs, for them to take no action until the case progressed to conviction in court, where there was a chance that the costs of the report would be paid by the court rather than by the solicitor
- there was said to be no clear template for what information needed to be included in psychiatric reports and the quality of reports and of liaison with local services varied considerably
- there were often limited resources for the rapid assessment of learning disability needs
- because needs were identified late in the process, proper assessment of conditions such as ADHD was not feasible within court timescales; some practitioners also reported that short sentences did not allow enough time to assess for ADHD in custody and that there was a high risk that young people's needs would be consistently missed.

Lord Bradley (Department of Health, 2009b) has recommended a review of the systems and processes for ordering court reports. Our study identified a number of areas that require clarification specifically in relation to the youth court. These include:

- the circumstances in which a psychiatric or psychological report should be ordered
- who in each locality is expected to write reports on specific issues such as mental health, learning disabilities, ADHD, speech language and communication needs and how reports are funded
- what the report should cover and at what point in the youth justice process it can be made available
- the process of providing written information at different stages of the youth justice pathway and how to minimise perverse incentives so that young people are not having to wait until the latest possible point for their health needs to be assessed and addressed, purely for financial reasons
- the circumstances in which workers can provide information to the court if a young person is already on the caseload of a local CAMHS team
- the status of advice provided to courts by CAMHS workers (ie. are they expert witness submissions, progress reports by CAMHS services etc).

Statutory supervision orders

This study found that the focus of most health practitioner activity in YOTs is at a late stage in the criminal justice pathway, delivering interventions to young people who have already entered the court system and are placed on statutory supervision orders (or what is now known as the Youth Rehabilitation Order - YRO). This suggests insufficient early identification of risk factors for poor mental health and other, hidden vulnerabilities. Young people's difficulties may be overlooked for many years, risking problems escalating and the young people passing in and out of the system

over several years and subject to a range of early stage disposals such as reprimands, final warnings, referral orders etc before they reach the stage where most YOT health resources are focused.

It should be noted that this study was completed before the introduction of the YRO; health practitioners had very few thoughts on the implications of the new Order for their work, although Sandwell YOT had introduced a much more systematic screening process for health and mental health at the point that a young person came onto the YOT caseload in order to improve the quality of information available to inform YOT and court decision making. This study notes a possible tension between the call to include more information on generic vulnerability in court reports and the need, on the other hand, to ensure that young people are dealt with in a way that is proportionate with the offence they have committed. The new scaled approach is clear that young people should not receive formal Orders for welfare needs if the offence severity does not warrant this. Where information on vulnerability is included in reports, magistrates may, therefore, need to be made aware of other work progressing *outside* the formal Order in mainstream services to support the young person's broader vulnerability so that they are satisfied that these needs are addressed.

This study would recommend a review of how the YRO is working, of the use of health related conditions in these orders and of the part played by YOT health and mental health work in supporting the scaled approach.

“With both prevention and community orders, it is clear that the poor assessment of health needs and the lack of targeted interventions, where individuals are considered to be at risk of harm to themselves, can mean that those vulnerable children and young people are not adequately safeguarded.” (Healthcare Commission & HMIP, 2009)

Improving identification and support at the point of arrest

Towards the end of our study, the Department of Health funded six pilot Youth Justice Liaison and Diversion projects to improve identification, awareness and support at the point of arrest for young people with mental health, learning disabilities, speech and communication needs and other issues compromising their well-being. These sites are being independently evaluated.

In addition, the Youth Crime Action Plan (HM Government, 2008) introduced triage workers in around 60 areas to address the increasing drift of young people into the youth justice system over the last decade. The role of these workers is to divert young people away from the formal youth justice system delivering restorative justice interventions (primarily with young people with lower level offences), screening for support needs, and helping young people access lower level health and support services where necessary. Our analysis of Youth Justice Board data in two sites

adopting this diversionary approach has revealed not only dramatic drops in the numbers entering the Youth Justice System but also knock on reductions in court throughput, in pre court and statutory orders, in custodial rates and remands. Triage workers are not trained in awareness of mental health, learning disabilities or speech language and communication needs and do not see all young people. However, triage workers in two sites have been linked with the pilot mental health point of arrest schemes, with some promising early outcomes. Triage workers have been trained to use the SQIFA youth justice mental health screening tool and to look out for learning, speech and communication needs.

In 2009, a small number of pilot point of arrest schemes were also established by the Home Office to improve identification and intervention for young people whose offending was alcohol-related. Although these pilots have now come to an end, the learning is currently being collated to inform other point of arrest work.

Screening and assessment

Assessment and screening tools

The main tools used by YOTs to screen for health concerns are ONSET, ASSET and SQIFA.

ONSET is a referral and assessment framework used in all Youth Justice Board prevention programmes before young people officially enter the youth justice system. ONSET identifies young people who would benefit from early intervention, any risk factors that should be addressed and the protective factors that should be enhanced in order to prevent offending.

ASSET is a structured assessment tool used by YOTs in England and Wales with all young people who have offended and who come into contact with the youth justice system. It takes into account the young person's offence and identifies a range of factors – from lack of educational attainment to mental health problems – that should be recorded if related to offending behaviour. The information can be used to inform court reports so that appropriate intervention programmes can be agreed. In addition, because each section is scored, ASSET can help to measure changes in needs and risk of reoffending over time. A score of more than two for mental health and emotional needs or substance misuse should trigger a further assessment using the SQIFA.

SQIFA (the Screening Questionnaire Interview For Adolescents) is a mental health screening tool attached to ASSET for workers without mental health expertise to use with young people on their caseload. This screening tool triggers a more detailed screening interview for adolescents (SIFA) by the YOT health specialist.

YOT health workers identified a number of difficulties with these tools. Concerns were raised by some health teams and YOT managers about their sensitivity in picking up mental health needs, particularly if the mental health issues were not seen to be related to the offending. Concerns were also voiced about their sensitivity to conduct disorders, speech, language and

communication needs and learning disabilities. It was felt that they required a high level of awareness of these issues in the worker who completes the core ASSET and ONSET assessment.

As reported earlier, research into the prevalence of mental health difficulties has revealed under-identification of mental health problems using standard ASSET screening processes (Harrington & Bailey, 2006). A national audit (Youth Justice Board, 2008) has identified a number of other problems, including poor identification of mental health needs among black and minority ethnic young people and under-reporting with regard to safeguarding, vulnerability and risk of harm. Furthermore, although early behavioural problems are a strong predictor of future offending, conduct disorder and a range of other negative outcomes (including higher risk of poor health and mental ill health), the section of the ASSET relating to behavioural problems does not trigger further assessment. The Youth Justice Board and a number of other government departments are currently in the process of reviewing and updating ASSET and screening systems for vulnerable young people to address some of these issues.

The Common Assessment Framework

The Common Assessment Framework (CAF) was developed as part of the previous government's Every Child Matters agenda and is being used by practitioners across children's services in England. It was intended to operate alongside other developments (such as the role of the lead professional) to help agencies provide a more integrated service for children, young people and families. It included a screening tool and a longer assessment tool. CAF was designed to assess the needs of children and young people at risk of not achieving the five key outcomes set out by Every Child Matters (HM Government, 2003). These are to:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

A few health practitioners said that they were starting to use the CAF routinely. However they were unclear at this early stage in its implementation how the CAF and ASSET assessment processes would fit together.

Screening tools for learning disabilities

As reported above, some practitioners felt that current screening tools were not able adequately to identify learning disabilities and speech and communication problems among young people in the youth justice system. To address this, workers in Youth Justice Diversion and Liaison pilots in the north east are piloting a rapid screening tool and processes for young people with learning disabilities and speech and communication problems to try to improve identification rates. The police in the region are also collaborating with workers to improve screening at the point of arrest.

The screening is based on the adult Learning Disabilities Screening Questionnaire (LDSQ) but also includes school achievement levels and compares these with the young person's chronological age. Large discrepancies should provide evidence to support a referral for further assessment by a specialist in speech and communication needs or learning disabilities.

The Communication Trust are also currently working with the Youth Justice Board to raise awareness among YOT staff of speech, language communication difficulties and their implications for young people on YOT caseloads

Fuller mental health assessments

The Youth Justice Board recommends use of SIFA (the Screening Interview For Adolescents) but, like the pan-London study of YOT health provision (CSIP & HASCAS, 2008), we found that mental health practitioners in YOTs were using a variety of other, more in-depth assessment tools.

Reservations about the SIFA related to:

- the lack of parental/carer (or teacher) input – practitioners felt this was important to get a clear picture of the young person's well-being and levels of functioning
- local CAMHS practices – it was easier to use the same tools as the local CAMHS teams so that working practices and referrals dovetailed
- the questions in the SIFA – these were seen as clumsily phrased and inappropriate for vulnerable young people
- sensitivity of the screening tool – SIFA was not considered sensitive to speech, language and communication needs and learning disabilities.

Tools used instead by YOT health practitioners to obtain a fuller assessment of mental health difficulties included:

- the Strength and Difficulties Questionnaire
- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)
- the Child Behaviour Checklist
- Becks inventory
- Children's Global Assessment Scale (C-GAS)
- the FACE assessment (youth version),⁴ which is used by forensic mental health child and adolescent services and includes elements of forensic risk assessment
- SAVRY – the Structured Assessment of Violence Risk in Youth
- JSOAP – the Juvenile Sex Offender Assessment Protocol
- AIM – the Assessment, Intervention and Moving on project for young people at risk of sexually harmful behaviours.

⁴ <http://www.face.eu.com/paperyp.html>

Screening in practice

Screening and assessment for health and mental health varied considerably between YOTs.

A few YOT health practitioners screened all young people placed on statutory supervision orders, regardless of their ASSET scores. One team only screened those on intensive supervision and surveillance programmes (ISSP), which are used as an alternative to custody. Other health practitioners waited for YOT case managers to refer young people, based on their ASSET scores for mental health and emotional needs or physical health. This more reactive approach to referrals was not considered reliable as it depended on YOT workers' awareness of mental health and learning disability needs.

One health team reported using the YOT database as direct source of referrals (thus avoiding the need for YOT case workers to refer). The health workers used information from the ASSET screening to identify, follow up and more fully assess all young people scoring over two in key areas. One team had noted an increase in referrals after switching to this more proactive approach.

All YOT interviewees used ASSET as a trigger for further mental health and physical health assessment. Three quarters of health workers said that the SQIFA was also used regularly in their teams.

However, the remainder of YOTs had either adapted or did not routinely use the SQIFA, for a range of reasons. Islington YOT felt the language and the focus of the SQIFA was inappropriate for this group of young people and had produced a revised version that was being piloted and which they hoped eventually to validate. One team had been discouraged by the YOT manager from completing the SQIFA due to the amount of paperwork it involved. Another thought the SQIFA was inappropriate if the YOT had its own health practitioner. Two CAMHS practitioners used their own CAMHS forms for referrals. Two other YOT health practitioners preferred to take informal referrals. Where the SQIFA was used regularly, health practitioners had also trained broader YOT staff in the SQIFA. In some areas, local CAMHS would not accept the SQIFA or the SIFA as a valid primary care assessment.

Physical health screening either involved the use of bespoke tools developed by the YOT health worker or local screening tools for children and adolescents.

Bradford YOT health team used a software wizard on the ASSET database to produce a list of young people scoring over two in key sections of the ASSET screening tool. They then screened all these young people further for mental health and learning disabilities.

Access to services

Interviewees in this study reported difficulties in accessing and referring to a wide range of services, as detailed below.

Specialist CAMHS

Half the health practitioners interviewed reported ongoing problems with accessing Tier-3 CAMHS, specifically for 16–18 year olds. Others reported long waiting lists in response to referrals. Frequently referrals for this age group were said not to meet the criteria for CAMHS, leaving health practitioners to support young people with multiple needs that, while none individually met the threshold for specialist support, together posed a significant risk to the young person's well-being. In two areas (Birmingham and Salford) services had specifically been commissioned to meet the needs of this 16 plus age group. In a further two areas, we heard of commissioning initiatives which had improved waiting lists for specialist CAMHS. In one area, the creation of multi agency and integrated children's teams was said to have reduced referrals to CAMHS by two thirds. This was achieved through young people being supported into local services or being provided with brief interventions guided occasionally by specialist guidance from CAMHS workers. In another area, CAMHS triage workers had been commissioned to filter through specialist referrals, supporting those inappropriately referred through linkage with other community services. Once again, this approach had reduced CAMHS waiting lists locally.

Even if young people were accepted by some specialist CAMHS, interviewees reported problems with the way many services were designed, which they felt did not promote engagement with their clients. One CAMHS required families to return an 'opt-in' form before they came to their first appointment. This meant that the families often 'failed at the first hurdle' by not returning the form. Furthermore, many CAMHS tended to be inflexible and often would only see young people by appointment at their office base, rather than offering an outreach service. If the young person failed to turn up on more than two or three occasions, their case was closed and they would go to the bottom of the waiting list again.

As reported above, in places such as Bradford and the Thames Valley area where health practitioners had formalised access to consultation with psychiatrists or specialist CAMHS teams, or had a foot in specialist teams, or where fast track arrangements had been negotiated, referrals to CAMHS were easier, as was the process of thinking through how their needs might be met if the young person did not meet the criteria for specialist CAMHS. Occasionally, the YOT health practitioner continued to work directly with the young person, supported by supervision from the CAMHS psychiatrist. In other areas, newly commissioned services such as Head 2 Head, Engage and Northumberland Tier 3 CAMHS had improved the rapidity of response and engagement with young people in YOTs. In Northumberland and Staffordshire, the no-refusal approach to referrals was thought to have reduced the chances of young people with multiple needs slipping into the gaps between services.

Some YOT health workers also complained that CAMHS, having accepted a referral, would provide them with very limited information to support their own ongoing work with the young person, even when they had made an effort to provide YOT information in the referral.

Learning disabilities and speech and communication needs

Interviewees also described problems making referrals to learning disability services for young people. These difficulties included:

- accessing appropriate packages of support for young people with mild to moderate difficulties or speech and language problems
- understanding local care pathways (which could vary from area to area) and lack of local resources to respond to need
- little attention strategically to developing formalised agreements to support YOT work for those with learning and speech and communication needs
- accessing support for young people with learning disabilities at transition to adult services (16 and 17 year olds).

Some YOTs had employed learning disability nurses to develop pathways to services and to put together packages of support for clients with mild to moderate learning difficulties.

Forensic mental health support and assessment

Health practitioners in most regions described inconsistencies in knowledge about and lack of forensic support to YOTs. In particular, they described:

- lack of forensic mental health assessment for courts
- lack of knowledge about how to initiate an assessment of young people for medium secure psychiatric units when very severe mental health needs and risks were identified
- lack of consultancy and training to support YOT health practitioners in assessing and balancing risk to others and risk to self (care vs control issues).

Holistic support plans

“The young person and their health worker together devise a practical ‘stress-busting’ action plan itemising changes to be made, which is agreed with the supervising officer and forms part of their attendance requirements subsequently. A treatment programme for explosive anger, for example, may include attending the gym three times a week, working in a YOS project team to prepare a garden for an old people’s home every Friday and Saturday morning, learning to read with the YOS education worker, and so on, as well as participating in individual anger management or DBT sessions.” (YOT health team manager)

Health and mental health interventions provided within YOTs

As previously described, although the original intention had been to refer young people in YOTs to outside services, many YOT health practitioners ended up delivering direct care as well. Some workers provided holistic support with practical issues in order to build up a relationship with young people and to motivate them to seek help and facilitate engagement and disclosure. Others supported specialist or forensic services (where these services were available) by monitoring and encouraging progress following contact with the forensic mental health psychiatrist.

YOTs offered a wide range of different therapeutic interventions.

Solution-focused therapy

A number of YOT health practitioners said they used solution-focused therapy, which they felt was particularly effective in engaging young people. Solution-focused therapy starts with the assumption that young people have the knowledge and ability to solve their problems themselves, and uses the therapeutic relationship to mobilise their strengths and problem-solving skills. It is a highly collaborative approach that puts the young person at the centre and focuses on building their natural resilience. The approach is usually delivered over a limited number of sessions, typically two to six (Youth Justice Board, 2004a). Solution-focused therapy has been found to result in moderate improvements for young people with depression, anxiety, and self-esteem problems, but not those with conduct problems, in comparison with other interventions (Kim, 2008). However, many studies are poorly designed and more research is needed before firm conclusions can be drawn about its effectiveness (Kim, 2008).

Other brief interventions

Brief interventions and motivational interviewing have been used with moderate success in paediatric care and with adolescents to support changes in health behaviour (Erickson, Gerstle & Feldstein, 2005). Brief interventions take a person-centred, non-directive approach, using questions to encourage the young person to explore the gap between where they are now and where they want to get to in their lives, sometimes followed by collaborative action planning. Sessions can be quite short, although there is some evidence that the longer the session, the greater the effect.

A growing evidence base supports the use of motivational interviewing for people with mixed feelings about making changes, particularly in relation to diet and alcohol use (Erickson, Gerstle & Feldstein, 2005), and tobacco use (Brown et al, 2003). The approach is also being trialled with risky sexual behaviour, cannabis use, and to encourage contraceptive use among girls. The approach is thought to be particularly well-suited to adolescents and young people with shorter attention spans (Channon, Smith & Gregory, 2003).

Most of the YOT health practitioners used motivational interviewing principles to promote health behaviour change. The approach was seen to be highly flexible, enabling them to make best use of their contact with the young person to encourage improvements in physical health care, substance use and emotional self-management.

Art and drama therapy

Drama therapy involves using role play, voice work, storytelling and similar techniques to help the young person express feelings or externalise internal conflicts and psychological distress. Art therapy uses a range of arts media and creative arts techniques to the same end. Art therapists work with people with post traumatic stress disorder (PTSD), autistic spectrum disorders, histories of sexual abuse, anxiety and panic attacks, depression and many other health and substance use-related issues (Youth Justice Board, 2004a). These therapeutic approaches vary greatly in the way that they are delivered and measurement of impact is difficult. There is some evidence of effectiveness with people with mental health problems (Youth Justice Board, 2004a; Daykin & Orme, 2008).

Only two of the YOTs we visited had access to art and drama therapy. The approach was seen to be particularly well suited to young people with limited language skills or who found it less threatening to act out their feelings in the third person.

Anger management

Many health practitioners used anger management in their work, either one-to-one with individuals, or in group work. Some programmes were designed by health practitioners themselves; others used recognised interventions such as dialectical behavioural therapy (DBT, see below), and incorporated other components.

Anger management interventions have been found to work best in a youth justice context when they are based on cognitive behavioural principles and delivered in combination with other evidence-based interventions to address risk factors, such as parenting training (Youth Justice Board, 2004a).

Cognitive behavioural therapy (CBT)

Many YOT practitioners reported using CBT approaches in their work, although it was unclear how many were trained CBT therapists, as recommended in national guidelines (NICE, 2005; Department of Health, 2008).

Cognitive behavioural therapy (CBT) has been shown to be effective in reducing reoffending rates (Lipsey, Wilson & Cothorn, 2000), and there is some evidence that it may be effective as part of group work in treating mood disorders, self-harm and anxiety disorders in young people in the youth justice system (Townsend et al, 2009). It is recommended that interventions using CBT

should be multi-modal in order to address other complex issues that may otherwise hinder young people's progress (Lipsey, Wilson & Cothorn, 2000).

Dialectical behavioural therapy (DBT)

There is a growing body of evidence to support the effectiveness of dialectical behavioural therapy (DBT) for the treatment of borderline personality disorder in adults (Binks et al, 2006; Bohus et al, 2004; Verheul et al, 2003). DBT employs a range of cognitive and behavioural techniques, including problem-solving, exposure training, contingency management (a system of rewards for progress) and behaviour modification. It has also been adapted to treat adolescents with mental illness (Miller et al, 1997) and those with high emotional vulnerability and volatility (Quinn, 2009). DBT has also achieved promising results in combination with other interventions (multisystemic family therapy and motivational interviewing) with young offenders with co-existing mental health and substance misuse needs. This approach has been trialled in the US as a resettlement package, the Family Integrated Transitions (FIT) programme, which starts in custody and continues through into the community over a four month period, with very promising initial results in terms of reduced re-offending and cost savings (Aos, 2004).

Only one YOT in our study said that they provided DBT, although staff in secure settings reported that training was increasingly being provided in this approach.

Family and parenting support

The Think Family strategy was introduced by the previous government in 2008 in an attempt to improve collaboration between children's and adult services to support the most disadvantaged families and children.

Research indicates that some of the most effective interventions for young people who offend are those that focus on improving the quality of the child's parenting. The effectiveness of fairly simple parenting interventions (the Incredible Years, Triple P Parenting and Strengthening Families, Strengthening Communities programmes⁵) has been well evidenced up until the age of 10 or 14 years, but not for children over this age.

For adolescents, interventions such as multisystemic therapy and multi-dimensional fostering, that focus not just on the family but also on the broader issues affecting the young person, appear to be more effective. However the over-riding message from the research is that very early intervention is most successful in achieving change in families with children showing signs of severe behavioural problems. Multisystemic therapy (MST) and functional family therapy (FFT, see below) have the strongest evidence base but they are also highly intensive and costly to deliver (although cheaper than custody as detailed earlier), suggesting that they should be targeted at those at greatest risk of persistent offending (ie. those whose behavioural problems start early in

⁵ For more information see the commissioning toolkit for parenting at <http://www.commissioningtoolkit.org/>

childhood). There is a less robust evidence base for less intensive parenting interventions with older children and those with less persistent behavioural problems.

Multisystemic therapy

Multisystemic therapy is designed to improve child and teenage behavioural difficulties, as well as other poor outcomes linked with conduct problems. It focuses on the entire family and also the 'ecology', or systems, surrounding the family. It is an intensive, time-limited treatment (four to six months) provided by professional therapists/caseworkers, supervised by clinical psychologists or psychiatrists. Workers have small caseloads and provide an outreach service with 24/7 availability. The care plan is developed with the child and family. Interventions are pragmatic and tailored to address the particular needs of the child and family. They may include work with school staff, peers, neighbours, and community organisations.

Reviews of the evidence for this approach were initially very positive (Brosnan & Carr, 2000); later systematic reviews were more cautious (Littell, Popa & Forsythe, 2005) – a discrepancy that has been attributed to errors in the selection of the studies reviewed (Littell, 2008). The jury is still out on the overall effectiveness of MST, although continuing research will add to the knowledge base and recent interim findings from a UK study look promising (Boseley, 2010).

The Department for Children, Schools and Families and the Youth Justice Board have rolled out 10 MST pilots across England in 2008/2009, to add to two pre-existing schemes that had links with local YOTs. Two pre-existing MST schemes were visited in the course of this study. It both serves as an alternative to custody for young people in the YOT and offers places to local children's services to avoid costly out of home crisis placements.

Functional family therapy (FFT)

Functional family therapy (FFT) is a manualised form of systemic family therapy for young people with teenage behavioural and offending problems (Sexton & Alexander, 2002). Like MST, it takes a collaborative, problem-solving approach, working with the family and child to build communication, negotiation and other skills through the therapeutic alliance with the worker. Whole family sessions are conducted on a weekly basis and treatment lasts between eight and 30 sessions over three to six months. A comprehensive system for replicating the fidelity of the model has also been developed. FFT has been found to be much more effective than routine treatment in reducing reconviction rates in adolescent offenders with conduct disorders from a variety of ethnic groups over follow-up periods of up to five years (Alexander et al, 2000). There is also evidence that it can lead to a reduction in behavioural problems among the siblings of the young

offenders. It is less expensive (\$5,000–\$12,000 less per case) than custody or standard residential care and can achieve savings in crime and victim costs of over \$13,000 per case (Sexton & Alexander, 2002).

Drop-out rates are also much lower for FFT, at about 10% compared with 50–70% in routine community treatment of adolescent offenders (Sexton & Alexander, 2002).

Many of the YOT mental health practitioners in our study said that they used attachment theory to make sense of their young clients' behaviour and to understand how it is linked with their parenting. Various parenting interventions were offered to YOTs clients and their families, but the quality was variable.

One YOT had a parenting worker in the health team. In others, there were good links with external parenting workers. In others parenting work was informal and followed no particular theoretical model or therapeutic approach.

More structured, evidence-based and intensive family and systemic approaches were offered in a small number of YOTs. Cambridge YOT used MST as part of their intensive supervision and surveillance programmes (ISSPs). In Peterborough the YOT point of arrest team had access to the MST team but, because of the cost, the treatment was reserved for young people with the most severe difficulties. Brighton and Hove YOTs were offering FFT as part of the first ever UK study of the approach with young people in the youth justice system. In Merseyside an adolescent Triple P parenting project was being delivered by Barnardo's, linked to the Liverpool community courts and working closely with the YOTs. Similarly, in Sandwell a Triple P parenting trained worker provided a service for young people and their families involved in the YOT.

Towards the end of our study, many more YOT health practitioners reported links with local family intervention projects funded through the 2008 Youth Crime Action Plan. These projects provided a semi-wraparound service (see below) aimed at changing behaviour in families and young people involved in anti-social behaviour through a process of 'challenge and support'. An in-house evaluation (with a comparison group) reported impressive initial reductions in anti-social behaviour (National Centre for Social Research, 2009) although a more recent study has challenged the robustness of the methods used to draw these conclusions (Gregg, 2010). Where good links had been established, health practitioners generally welcomed access to these projects. However they also reported that many of their referrals did not meet the very high threshold for entry to these services.

The SAFE study (The Study of Adolescents' Family Experiences) is the first randomised controlled trial of functional family therapy (FFT) in the UK. It is being conducted by the National Academy for Parenting Practitioners at the Institute of Psychiatry (King's College London) in partnership with Brighton & Hove Youth Offending Services (YOS), Targeted Youth Support Services, Anti-Social Behaviour Team and West Sussex YOS. http://www.uel-fts.org/ongoing_research.htm

Multi-dimensional fostering treatment (MDFT)

Multi-dimensional fostering treatment (MDFT) places young people who cannot live at home with foster parents who have been intensively trained to provide a structured environment to promote social and emotional skills. The young people are monitored and supported at home, in school, and in leisure activities. Programme staff work closely with foster parents, and may also work with teachers, YOT workers, employers, and others in the young person's life to ensure consistency of approach and reinforcement of pro-social values. Intensive work also takes place with the biological family with a view to eventual reconciliation. Reviews have indicated good outcomes in terms of reduced likelihood of further arrest (Farrington & Welsh, 1996) and reduced violence in adolescent male offenders (findings are less clear cut for females) (Hahn et al, 2005). The approach has also been shown to reduce offending and to be more cost effective than custody and other residential group care settings (Aos, Miller & Drake, 2006). The evidence for effectiveness of MDFT for mental health difficulties is promising but not so strong (Office of Technology Assessment, 1991)

None of the YOTS we visited had access to multi-dimensional fostering treatment (MDFT) or other such intensive fostering programmes. A pilot MDFT programme had been launched in Hampshire and we were told that good working relationships had been established with the local YOTs.

Wraparound

Wraparound service planning describes the organisation and co-ordination of services for children and families with complex needs in contact with several agencies. These services might include clinical therapy, substance use treatment, special education, medication, caregiver support, public assistance, employment, housing, medical health care, mentorship programmes, transport and juvenile justice and child welfare. Wraparound has been adopted as a way of delivering personalised packages of care to young people with severe mental health problems. Its philosophy emphasises community-based, culturally competent, integrated, comprehensive services provided in the least restrictive environment and with the full participation of the child's family (Carney & Buttel, 2003).

“Young people don’t like being passed from worker to worker.” (YOT health practitioner)

The key principles guiding this approach are that the views and preferences of the child and family form a central part of the planning process; interventions should be individualised and strengths-based and cover a range of needs; natural supports such as friends, extended family and neighbours should be engaged in the process, and approaches should be flexible and adequately funded (Bruns et al, 2005).

The wraparound approach is very much in its infancy in terms of the robustness of the evaluations completed. However, a small number of studies have found:

- reduced psychiatric inpatient, custodial or residential placement, and thus the overall cost of care (Burchard et al 2002; Clarke et al, 1998)
- improved educational engagement and performance (Carney et al, 2003)
- less running away from home (Clarke et al, 1998)
- improved behavioural problems in boys (Clark et al, 1998)
- increased emotional and behavioural strengths (Pullman et al, 2006)
- less police contact (Carney et al, 2003)

However evidence for the effectiveness of this approach in reducing reconviction rates is mixed, and more, better designed studies that include comparison groups are needed. The approach also requires more consistency in its delivery from location to location for effective evaluation. Wraparound has, however, been seen as useful in engaging young people with complex needs (Burchard et al 2002).

As reported above, Family Intervention Projects use an approach very similar to wraparound services. We found that some of the health practitioners we interviewed often used a wraparound approach to help young people with practical problems – for example, taking them to appointments, working with other YOT staff to support well-being etc.

“[Young people in the YOT] need more practical kinds of help really, and engaging them over a period of time...not having any boundaries about what you can and can’t do...if the issue came up that they needed accommodation, you’d just get on and do it and while you were doing that they would see it as help and they would talk to you more and once you had sorted that out with them then they would come and talk to you more...I think there’s a lot more mileage in that. The only difficulty with doing that is ...workload, you can only have a certain caseload...I know that a lot of teams weren’t able to help in this way because of pressures on the caseload.”
(YOT health practitioner)

Gaps in service provision and knowledge

Learning disabilities and speech, language and communication needs

As highlighted above, high numbers of young people in the youth justice system have learning disabilities or speech, language and communication needs. However, few interventions have been developed for these young people, and those that are used are poorly evidenced and under-researched.

A few YOTs had introduced speech and language therapists to identify and screen young people more effectively for these difficulties. In the Leeds YOT, speech and language interventions had achieved some promising improvements in the young people's functioning.

However, echoing the findings of the CAMHS review (Department for Children, Schools and Families & Department of Health, 2009), a number of YOT health practitioners reported lack of resources locally to support young people with these difficulties.

"Learning disability services...are very under resourced...We can get the assessment done in maybe a month but then it's difficult. I think they are more set up for the medium to severe learning disability needs. They don't really have much for mild learning disabilities and if they needed an intervention...if they needed a nurse (like my lad) that was six months away and if they needed a psychologist, that was over a year...and then that borderline group...it's really more about consultation with other professionals about how they might communicate and develop their intervention as a package." (YOT health practitioner)

BME groups

Although there is evidence that young black and minority ethnic (BME) people are over-represented in youth custody and in the youth justice system as a whole (House of Commons Home Affairs Committee, 2007), YOT health workers said that referrals for health care were generally lower than for white groups. However, there are no national data on access and referrals for health support in YOTs. Access to primary healthcare is of particular importance if health needs that can have a long-term impact on life chances are to be addressed at an early stage. Furthermore, there are suggestions that some risk factors and early signs of poor mental health among some BME groups are missed or misinterpreted and so not treated, leading to problems escalating and accounting in part for the over-representation of BME adults in more restrictive mental health care settings (Malek, 2004).

A number of workers felt that there was a greater stigma attached to mental illness and to receiving mental health treatment among some BME communities.

The Strengthening Families programme (for families with children up to the age of 14 years) has been used in some YOTs, and is one of the few parenting interventions that has a promising evidence base for effectiveness with families from BME communities (Wilding & Barton, 2009).

None of the health practitioners we interviewed mentioned links with the Department of Health's Delivering Race Equality community mental health development workers (Department of Health, 2004) or cited any specific projects for young BME people. Our findings suggest that more research is needed into provision of specialist support for BME young people in the youth justice system, and into what works with BME communities.

A young man of black African heritage on the YOT caseload was identified by use of SQIFA as having some signs of ADHD. The YOT health worker (who in this case was also of black African heritage) talked to the family and the young person about what had been picked up, how this might be affecting their son's progress in school and his life chances, what could be done to minimise any difficulties that their son might face, and what might be done to help him. The family were concerned that their son might be labeled if he was in contact with mental health services and the worker spent a long time over several visits discussing with them the pros and cons of the various alternatives. The family decided that they did not want to be referred to a specialist for assessment and possible medication; instead they agreed that the YOT health practitioner would liaise with their son's school about what had been discussed, talk to the school nurse about the need to monitor his progress and well-being and to do some awareness raising with the young man about the possible implications for his learning and decision-making.

Resources for young women in YOTs

Young women who offend, and particularly those in custody, are generally acknowledged to have higher levels of mental health and health needs than young males in the youth justice system (Douglas & Plugge, 2006). The Corston Report (Home Office, 2007) also describes the multiplicity of complex needs among women in the criminal justice system and recommends more holistic and multi-agency approaches to helping them away from offending and improve their life chances. In particular, it recommends improved access to community support in the form of a wider network of women's centres and one-stop shops to which women offenders and those at risk of offending can be referred.

Many YOT health practitioners in our study reported that young women often needed different and more intensive support because of their greater vulnerability and safeguarding concerns. Two interviewees also noted that young women were often more willing to engage with talking therapies than their male counterparts. Most interventions with young females in YOTs involved one-to-one work.

During the course of this project, teenage health demonstration sites (THDS) were set up in four locations across England to try to improve access to services for those most at risk of poor health and mental health outcomes. The Hackney THDS had linked with the local YOT and had screened all young people entering the YOT caseload after a court disposal, using a detailed health checklist. This had found high levels of health needs for all young people: 36% had chronic health problems and 77% required follow up for health issues. In addition, a range of specific health needs were identified among the young women, mostly relating to their sexual health. All required contraception advice and provision and all were prescribed contraception on site. In one instance, a contraceptive implant was fitted on site. In another, emergency contraception was indicated and provided. Several young women needed a pregnancy test; one was pregnant but not receiving ante-natal care. She was given early pregnancy advice and referred to antenatal services. This pilot project reinforces the need for a more systematic and intensive focus on the health needs of young people in YOTs as a whole.

Most of the interviews with YOT health practitioners were conducted before one stop shops for women in the criminal justice system had been established by the last government in response to the Corston Report (Ministry of Justice, 2010). However, mental health workers in one of the Home Office point of arrest pilot projects, in Wolverhampton, had developed good links with one stop shops in their area and had valued the support provided to some vulnerable women who had been identified through point of arrest screening.

Engaging young male offenders

There is growing recognition of the difficulties experienced by men in accessing health services (Health Development Agency, 2002). A recent report from Mind (2010) has highlighted the many barriers preventing men from seeking help at an early stage when experiencing mental health problems. These include:

- socialisation, which leads men to believe that they should be seen as strong and ‘copers’
- a tendency for stress to manifest as physical symptoms, which are then missed by primary healthcare workers
- negative experiences of GPs that discourage disclosure of mental health issues
- lack of accurate and easily accessible information about what help is available
- a tendency to adopt negative coping strategies in response to stress, such as anger/violence, drugs, drink, gambling, which are taken at face value and not recognised as masking underlying mental health issues.

“I was loath to ask for support...my pride gets in the way about opening up with my feelings and asking for help and getting support.” (Focus group member (Mind, 2010))

As a result, men described how they had to reach a crisis before they sought (or received) help with mental health problems.

In our interviews, many YOT health practitioners said that young men would rather be seen as criminals than as mentally ill. They also said that talking therapies were viewed with suspicion and the language and approach used in these therapies could be experienced as alienating by some young men.

As highlighted earlier, YOT caseloads include young people with the greatest number of health and mental health needs, the majority of whom are men. YOTs offer an excellent opportunity for PCTs to access a population at high risk of some of the greatest health inequalities. However, as reported above, many YOTs are not able to provide point of entry generic and good quality health screening. The Hackney THDS project identified many young men needing follow up with health problems, demonstrating the effectiveness of targeted, systematic screening for this group. Early intervention has the potential to save considerable costs across several government department budgets.

Throughcare and resettlement

The YOT health practitioners we interviewed did not often visit young people while they were in custody but they did:

- liaise with healthcare and mental health teams
- coordinate health packages for the young person's release
- attend discharge meetings for those identified with ongoing healthcare needs.

Some also supported applications for a 'vulnerability assessment' to inform the Youth Justice Board's decisions about placing young people in secure children's homes, rather than a young offender institution. Lone health practitioners in YOTs told us that they struggled to cover the entire youth justice pathway in their work and that they had insufficient resources to work with young people in custody.

Discussions with mental health teams working in the young people's secure estate indicated that not all were aware of the potential link to local health services provided by YOT health practitioners. Linkage with local YOT health practitioners could be particularly helpful at point of release when young people have been placed in custody a long way from home and need to be linked up with local CAMHS and other health support services in their home area.

A few health practitioners felt that young people with mild to moderate learning disabilities and mental health needs would benefit from a co-ordinated, wraparound approach, particularly at the point of release from custody. In the case of those with severe mental health needs, there was little evidence of the Care Programme Approach being used to ensure continuity of care following release. Although some young people were placed on licence, and so received intensive,

offending-focused supervision on release, there was no evidence of intensive evidence-based therapeutic packages (such as the family integrated transitions therapeutic approach that is used in the US with young people and their families post-release) in the locations we visited.

Outcome measurement

Most YOT health practitioners collected information about referrals and workloads but did not generally have systems in place for measuring the impact of health interventions. Similar variability in practice was found in monitoring outcomes. One YOT health team worked with safeguarding and LAC nurses to provide reports for commissioners on activity and areas of need. Some mental health practitioners used an assessment tool to monitor outcomes – for example, a few used the Strengths and Difficulties Questionnaire (SDQ), and the FACE assessment used in Stockton and Middlesbrough also had outcome monitoring built into it. Some health practitioners had become involved in the pilot of the CAMHS Outcomes Research Consortium (CORC) ‘basket’ of outcomes monitoring tools. This includes:

- the Strengths and Difficulties Questionnaire (SDQ) – a 25-item questionnaire completed by referred children aged 11–18 years and parents of children aged 3–16 years before the first appointment and six months after. The SDQ has not been specifically validated for children over the age of 16 years but it has been used for 17–18 year olds in some community surveys
- Commission for Health Improvement (CHI) Experience of Service Questionnaire (ESQ) – this is completed by all clients aged nine years and over at six months after first appointment. It asks young people and their parents about how they found the service and whether they would recommend it to others. Items were developed from discussions with service users
- the Children’s Global Assessment Scale (CGAS) – this is completed by practitioners for all age groups after the first appointment and six months later. The 1–100 point scale allows service providers to rate the extent of child and family difficulties at first contact and six months later.

There were mixed views among health practitioners about which were the most appropriate tools for evaluating outcomes. The SDQ was seen as an effective measure by some, but reported as not being appropriate for young people aged 16–18 years, who are the main age group served by YOTs. Others felt that the CORC tools were not suited to YOT clients because of the complexity of some of the language.

We also found wide variations in how YOT health workers monitored satisfaction with the services they provided. Some did not record clients’ satisfaction with the service at all. A few said they used the YOT ‘What do you think?’ satisfaction survey built into ONSET and ASSET. The CORC also has a service user satisfaction tool.

Managing transitions

There has been growing concern about young people's experiences of transition as they move from children's services to adult services (Transition to Adulthood Alliance, 2009; Department for Children, Schools and Families & Department of Health, 2009). The National Service Framework (DH, 2004) provided specific guidance to PCTs to ensure that services were available to young people up until the age of 18, but such services were noted to be absent still in many areas. A number of reports have highlighted poor management of transitions and the very different needs of young adults to those of younger children and older adults – needs that are not currently met by either CAMHS or by adult mental health services (YoungMinds, 2006).

A number of transition points were identified during this study as causing problems in particular for young people in the youth justice system with mental health, emotional well-being, learning disabilities and speech, language and communication needs. These included:

- the frequent gap in mental health and learning disability services for young people aged 16–18 years, due to different funding and commissioning practices
- the lack of out of hours provision for young adults in many areas
- the lack of recognition in the majority of adult services of conditions associated with childhood such as ADHD, conduct disorders etc
- the lack of recognition in adult community and inpatient services of the very different needs and developmental characteristics of young adults.

“We’ve had a hopeless situation here for years now. We’re told that CAMHS should deal with 16 and 17 year olds but the consultant psychiatrist here has refused to do it unless he gets resources. Most of the kids we see are this age, we just can’t make referrals.” (YOT operational manager)

Most practitioners interviewed during this study argued that the 18 year olds in YOTs had the same range of support needs as those aged under 18. In their experience, adult services were less likely to be focused on preventative, early intervention and mental health promotion work, or on family and parenting work. They were also felt to be less like to be aware of speech and language needs (Bryan, Freer & Furlong, 2007) and hyperactivity problems (Youth Justice Board, 2004a; National Association of Probation Officers, 2009), to have higher thresholds for entry than children's services, and to be poorly designed for young people.

Early intervention in psychosis teams were mentioned by some YOT practitioners as an example of a more successful model for managing mental health transitions. These teams are funded through adult mental health funding streams but work with a very broad age range (14–35 years).

Work with young people with sexually harmful behaviours

Not all YOT health workers/teams mentioned work with young people with sexually harmful behaviours. Some health workers with poor links to regional or local forensic consultation, said that they struggled to manage young people who were at risk of offending in this way. They also talked of not always knowing what resources were available either nationally or locally to support and manage young people at risk of these kinds of offences. However multi-agency public protection arrangements (MAPPA) were generally seen as a useful for improving management of high-risk young people and for sharing decision making.

YOT health practitioners who were supported by regional forensic teams said they valued this collaboration with forensic psychologists and psychiatrists in this work and in developing effective risk management and assessment procedures. Through screening at point of arrest, one YOT health practitioner described having been able to identify and remove from a very high risk family situation a 13-year-old boy suspected of sexually harmful behaviour. Working with others, this worker had been able to facilitate very early intervention for the boy from the NSPCC, initiate public protection mechanisms through MAPPA and link the boy with the school nurse so that his chronic health issues could be monitored and referred on to the local paediatric team. By the time the boy came to court, this plan had been progressing for many months, with very positive outcomes in terms of his risk management and safeguarding. The support package and the work completed with him also influenced the final prosecution decision.

A number of YOT health practitioners/teams were using the Assessment, Intervention, Moving On programme (AIM) developed in Greater Manchester, and another used the STOP sex offender treatment programme. The AIM mode (Audit Commission, 2001) was described as particularly useful as it links with the YOT ASSET assessment and collects information from multiple sources. It also outlines assessment procedures for young people with learning disabilities and for children under 10 years of age who display sexually problematic behaviours, and assessments for parents and carers.

Generally, interviewees felt that improved national and regional guidance was needed to support the work of MAPPA and ensure effective management and safeguarding of young people at risk of sexually harmful behaviour and victims. Nearly three quarters of these young people have themselves been the victims of sexual abuse (Vizard et al, 2007). At the time of writing, the Department of Health and Department for Education were developing guidance on this topic.

Involving young people

There is an increasing expectation, both nationally and internationally, that children and young people should be involved in decisions that affect them and in shaping the services they receive (United Nations, 1989; UNICEF, 2008; Department for Children, Schools and Families, 2004).

The National Children's Bureau (2009) has recently reviewed participation in the youth justice system and identified significant scope for improvement in participation by young people in YOTs and secure settings.

Involving young people in actively shaping their pathway to 'recovery' is also seen as a core component of effective mental health practice (Sainsbury Centre for Mental Health, 2008). A recovery approach to mental health involves the young person (and their family) having a central voice in deciding their goals and the help they need to progress towards regaining an 'ordinary' life. The mental health worker's role is to facilitate this process, not to be the major decision maker.

Discussion with YOTs health workers indicated a general commitment to working with and actively listening to young people when considering how best to meet their health needs. Islington CAMHS-YOS, for example, stressed their very collaborative approach with young people when putting together packages of support.

Two projects had also conducted formal consultations with children and young people. Lewisham ARTS team had completed a consultation exercise with their young service users about what health services they wanted, in what shape and form and what they saw as their main needs. In Yorkshire and Humberside, a focus group had been held with young people to inform the regional commissioning plan for children and young people in contact with the youth justice system.

However, there was generally limited evidence of young people's active involvement in reviewing and informing the design and delivery of the health services they were using. This contrasts with developments in the voluntary sector, for example, where this level of participation is becoming more common. The voluntary sector organisation St Christopher's Fellowship (which runs supported housing projects for looked after young people) has trained and paid young people using its services to develop recommendations for improved participation, to train up and supervise other service user representatives and to inspect homes in other regions.

Newham Community Project

Two local residents launched a community project on an estate in Newham to reach out to young people in contact with the youth justice system. The project was led by the young people themselves and raised a number of issues about how engagement might be improved with 'hard to reach' groups. The project facilitator confirmed that many young men in the group were very nervous of mental health services and feared being labelled, despite often having very high mental health needs. However, they would access the Newham project regularly and welcomed informal help from workers with whom they had built a relationship. Those who had made some progress acted as peer 'outreach workers' to spread the word about the support available to other young people at risk of offending in the area.

In Camden, a similar engaging project had been set up by youth workers on a local estate. A clinical psychologist provided frontline youth workers with supervision and consultation and delivered treatment remotely via the frontline youth workers.

Conclusion

Young people in the youth justice system have well-documented high levels of mental and physical health needs and vulnerabilities. For many, these needs remain unidentified and unaddressed, with significant long-term effects on their life chances and physical and mental health and well-being. These young people are among the most disadvantaged in society.

This study found a very wide range of models in place for meeting the health needs of young people in YOTs. Health practitioners in YOTs were evidently working diligently and energetically to support young people in contact with the youth justice system, often in close and productive collaboration with other agencies and teams. However, we found widespread evidence of the inadequacy of existing resources to address the full extent of the health needs of these young people. An important opportunity is clearly being missed to reduce future health and criminal justice costs through prevention and early identification and intervention with this high risk group. We also found evidence that health practitioners are mostly only accessing young people at a very late stage in the youth justice pathway, with little or no capacity for preventive work.

We have described in this report the range of models currently being used to provide access to health and mental healthcare in YOTs. Drawing on our own and other findings, and practitioner and stakeholder views, we end with some recommendations for ways to improve the healthcare provision to which young people in YOTs are entitled and which has the potential not only to achieve better outcomes for a highly vulnerable group but also to produce long-term cost savings to the national economy.

Finally, we have drawn on our findings to draft a commissioning toolkit setting out the components of a comprehensive health service for young people in contact with the youth justice system. This toolkit can be used by Children's Trusts/Local Authorities, PCT commissioners, regional commissioners (or any other governance or commissioning structures brought in by the new government) to identify and remedy gaps in provision.

Recommendations

Early intervention

Efforts to address health and offending needs and risks in the youth justice system should build on a firm foundation of very early and non-stigmatising identification and intervention, using evidence-based approaches, to prevent multiple adverse outcomes and reduce re-offending. Children's (and some adult) services outside the youth justice system should take primary responsibility for these children and young people's outcomes at this earlier stage in their pathway by linking families up with cost-effective and proven parenting and health interventions.

YOTs and mainstream children's and health services need to work closely at their interface to ensure that young people receive the help they need as early as possible within mainstream services. Health teams linked to YOTs also need to liaise with those making decisions in the youth justice system about the health needs and packages of health support available to promote progress and address risks. Early intervention with health and mental health problems may prevent a revolving door of offending with unaddressed need escalating and with negative impact on children and young people's life chances. It may also reduce re-offending and future costs.

Equality, equity, access

Young people in the youth justice system are at high risk of health inequalities and poor life chances and as such are a key target group for health services charged with narrowing the gap in outcomes between the highest and lowest achieving children.

This study found that these young people face ongoing problems accessing specialist health and social care support. This is due in large part to inflexible exclusion criteria, failure to recognise complex and safeguarding needs, and poor design of services that are not experienced by young people as accessible or engaging. These service design issues require urgent attention by commissioners.

Strategic commissioning

There is a need for a more strategic approach to commissioning YOT health provision at local and regional levels. We have produced a checklist of the key health activities and functions required to meet the needs of young people across the entire youth justice pathway for use by local commissioners as a mapping tool and action plan to guide service design and development (see Appendix 1). Service level agreements and memoranda of understanding should be developed with lead agencies (both voluntary and statutory) responsible for addressing the needs of young people throughout the youth justice pathway. SLAs supporting the commissioning of health practitioner posts should include contingency plans to cover gaps (in excess of six weeks) in the availability of healthcare staff due to turnover and absenteeism.

Virtual teams and networks (see Bradford and Islington CAMHS-YOS models) could be established at local and regional levels but there would need to be a realistic assessment of the implications of a virtual team approach on the existing workload of those in mainstream services. Virtual teams should also link with secure settings.

Each local authority should develop a 'suite' of care pathways locally for vulnerable young people with multiple or complex needs who offend. A few areas had begun this work to develop clearer systems to support the work in YOTs. It may also be useful for local areas to cluster together to commission some services regionally:

- to support YOT health practitioners (particularly in rural areas),
- to ensure that all young people in secure settings get the health and mental health services they need
- and to create better continuity of support in and out of secure settings.

A resource could be developed in each region (similar to the Thames Valley Forensic mental health model) or even in local areas (in line with the Islington model) to provide expert 'outreach' consultation and advice for frontline workers. This consultative model could provide more specialist assessment, supervision, problem solving and advice for all staff working at the frontline with vulnerable young people (such as YOT caseworkers, targeted youth support, Looked After Children, health workers, workers in secure settings, CAMHS specialists working with vulnerable young people, those working with looked after children and young people etc). The team would include experts in forensic mental health, significant substance dependency, health inequalities and work with young people at risk of sexually harmful behaviours. Access to high quality forensic and clinical supervision is essential to effective mental healthcare provision with this group of young people.

Healthcare provision in YOTs

We found a range of models of health provision in YOTs, and also considerable inconsistency in what was provided. It is clear that a single YOT health worker cannot meet the whole range of health and mental health needs found among these young people. Professional isolation from mainstream services may also reinforce the social exclusion of vulnerable young people and limit the extent of support that can be offered. Furthermore, YOT health provision was provided too late in the youth justice pathway, with key opportunities missed to target health inequalities and vulnerabilities early on.

Health provision does not have to be based full time in YOTs but appears to work best when there is a regular and systematic presence of health and mental health workers in these settings. Regular attendance allows YOT health practitioners access to consultation and advice and facilitates confident management of cases. It is important that any health presence in the YOT also has very strong links to a broad range of local mainstream services.

There are high rates of health inequalities among young people who offend. Screening and support for health needs should occur at the first point of arrest. Any progress made as the young person continues through the youth justice system should be reported back to courts and to YOT teams so that health and mental health care, safeguarding and risk management become an integral part of Youth Rehabilitation Orders (YRO). Practitioners responsible for screening should be hyper-vigilant for particular risk factors for poor outcomes such as early signs of behavioural difficulties, risk of school under-achievement, childhood maltreatment, young females who are offending, homeless young people and young people from groups that are over-represented in the YJS and who are not accessing primary care services.

Local YOTs need to link more closely with parenting provision in their areas and should recognise the importance of evidence-based family and parenting interventions in reducing offending and improving mental health and other outcomes for children and young people.

Health teams based within YOT teams should consider carefully how they build in systematic structural linkages with local comprehensive CAMHS, children's services (particularly targeted youth support) and voluntary sector provision, to avoid duplication and professional isolation.

Learning disability and speech, language and communication needs

There is a current gap in provision within the youth justice system for children and young people with mild to moderate learning disabilities and a lack of clarity as to whether speech and communication needs can realistically be met by local services. These issues require careful consideration by local commissioners and regional leads.

Liaison with courts

Echoing the findings of Lord Bradley's review, there is a need for a review of the way in which psychiatric reports are commissioned and ordered, with a particular focus on Youth Courts. Health workers should provide feedback to courts on lower level health issues (see, for example, the adult South West Court Report Pilot) and advise and co-ordinate input when psychiatric or psychological assessments are required.

Point of release and resettlement

Children and young people in custody have the highest needs. There is a need for greater use at the point of release of evidence based approaches such as Multi Systemic Therapy, Functional Family Therapy, Family Intervention Projects and intensive wraparound services, (possibly supported by mentors). When young people have been receiving specialist care in secure settings, access to community based specialist CAMHS or transition services should be fast tracked with immediate contact guaranteed on release. The Care Programme Approach should be used in all such cases. These services should adopt an assertive outreach approach to maximise engagement.

Transitions

Commissioners need to address the gaps in mental health and learning disability services for young people aged between 16 and 18 years, and specifically services to support the transition from children to adult services. Consideration should also be given to improving the design and delivery of adult mental health and learning disability services to suit the needs of young adults. This transition point is an important opportunity to intervene early with emerging mental health and health difficulties. Most mental health difficulties start in adolescence so it is a crucial time for early intervention.

Participation

The work on developing care pathways for those in contact with the youth justice system should be actively shaped by children and young people with experience of the Youth Justice System.

Young people from BME communities

YOT health teams should systematically track their rates of engagement with BME groups and compare these with the minority ethnic profile of YOT caseloads, to ensure equity and accessibility of provision. Commissioners and providers should make contact with BME community development workers for mental health to support the development of culturally competent services.

Assessment and outcomes

A wide variety of health and mental health assessment tools are currently being used in different localities, across different agencies and even at different stages in the YJS pathway. Cross-government developmental work is progressing to review and standardise current assessment and outcome monitoring tools and systems for vulnerable young people. Greater attention is needed to measuring outcomes in health and mental health work with young people in the youth justice system.

Appendix 1: YOT health service commissioning toolkit

All YOT Health functions should build on a robust assessment of the needs of vulnerable young people in the local area (including those in secure settings).

Area:			
Health functions in YOT health team	Potential service providers	Who fulfils this role?	SLAs/protocols in place?
Screen all young people for <ul style="list-style-type: none"> Physical health needs Mental health needs (including early signs and risk factors for poor mental health) Early starting behavioural problems SLCN Learning disabilities Safeguarding concerns and childhood maltreatment Alcohol misuse Drug misuse Educational under attainment or drop out Foetal alcohol syndrome 	(eg. General nurse, LAC nurse, police custody nurse, YOT health practitioner, school nurse, point of arrest, triage worker etc)		
Full assessments required <ul style="list-style-type: none"> Mental health rapid assessments Forensic mental health Child in need or CAF Learning disabilities SLCN Neurological conditions and brain disorders 	(eg. Paediatric, Specialist CAMHS, forensic CAMHS, LD psychologist, speech and language therapists, CAMHS or social care crisis teams etc)		

<p>Point of arrest work</p> <ul style="list-style-type: none"> • Support young people with lower level needs into services • Liaison with CPS/courts/bail support workers • Negotiating access to specialist or forensic CAMHS • Negotiating access to specialist drug services • Negotiating access to specialist alcohol services • Negotiating other specialist care • Hold cases pending acceptance and handhold into new services • Monitor and troubleshoot attrition from specialist services 	<p>(eg. YOT health practitioner, point of arrest rapid response mental health, drug, alcohol workers, CAMHS vulnerable children and young people's outreach worker)</p>		
<p>YOT liaison function</p> <ul style="list-style-type: none"> • Receiving YOT/Secure estate health referrals • Receiving YOT/Secure estate mental health referrals • Receiving YOT/Secure estate LD/ SLCN referrals • Mental health liaison with YOT • Health liaison with YOTLD liaison with YOT • SLCM liaison with YOT • Liaison with adult mental health services • Liaison with Police, CPS and courts 	<p>(eg. YOT health practitioner, LAC nurse, voluntary sexual health service, other services for vulnerable young people)</p>		

Visits to secure settings and sentence /resettlement planning/management <ul style="list-style-type: none"> • Liaison with healthcare teams • Relationship building with young people before release • Attending reviews • Resettlement planning and liaison with services • Resettlement support 	(eg. YOT case manager, YOT health practitioner, Inreach teams)		
Health interventions <ul style="list-style-type: none"> • Chlamydia screening • Immunisations • Smoking cessation and relapse prevention • Some prescribing • For sexual, physical problems and for minor injuries • Health check for those identified with learning disabilities as per recommended best practice • Advice regarding sexual health and contraception • Treating general health conditions • Mental health and emotional well-being • Lifestyle advice: motivational interviewing for smoking, alcohol, drugs, nutrition, exercise • School liaison and attendance 	YOT health practitioner, LAC nurse, sexual health service, other model		

<p>Mental health interventions and substance misuse (IAPT approach)</p> <ul style="list-style-type: none"> • Stress and anxiety management • CBT • Anger management groups • Life coaching/skills, ADHD life skills development/advocacy and wraparound support • Family conciliation and intensive parenting support • Motivational interviewing and brief interventions • Bereavement counselling <p>Substance misuse specific</p> <ul style="list-style-type: none"> • Education and harm reduction work • Relapse prevention work • Mental health interventions if these require a substance misuse specific focus <p>Support for well-being</p> <ul style="list-style-type: none"> • Education, training and employment support • Leisure activity/access to physical and positive activities • Peer support/mentoring 	<p>YOT mental health workers/voluntary sector services/Think Family co-ordinator</p> <p>YOT drug and alcohol worker</p> <p>Connexions, YIPs/YISPs/Children's preventative services.</p>		
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Specialist mental health provision for those in YOTs <ul style="list-style-type: none"> • Evidence based parenting work (FFT, MST, SFSC) • DBT and specialist CBT • Sex offender treatment (AIM/STOP approach) • Multi-dimensional intensive fostering • Specialist counselling • Prescribing for mental health/developmental difficulties • Prescribing for substance misuse • LD specialist packages of care 	Generic CAMHS/LD services/Forensic CAMHS/intensive fostering/Early intervention in psychosis services/Tier-3 substance misuse services		
Training and consultation provided to <ul style="list-style-type: none"> • All YOT case managers in speech and language needs • All YOT case managers in mental health awareness and care pathways • All YOT case managers in learning disability care pathways • magistrates and court users in speech and language needs/LD/MH/etc • generic CAMHS regarding work with young people who offend /forensic issues/SLCN/LD • Consultation for parents and schools re speech and language needs 	Speech and language Forensic CAMHS specialist Sexually harmful behaviours LD		

System for consultation for health workers in YOTs from those with knowledge of: <ul style="list-style-type: none"> • forensic mental health • health inequality work, • sexually harmful behaviours, • paediatrics • dependent drug and alcohol • speech and language problems, learning disabilities 	e.g. Are there services locally who could support the professional development of the health practitioner, who could provide supervision and telephone consultation		
System in place for supervision by or linkage with local relevant health or mental health team			

Appendix 2

Topic guide for YOT service audit: health practitioner role in YOTs

- Description of health and mental health arrangements
- Where is the team/worker based?
- How is provision funded?
- Number, ethnicity of health practitioners, how long in post?
- What is the professional background of the Team members/worker?
- What competencies does the team need?
- What tiers do they cover?
- Is there a formal protocol/service level agreement with CAMHS/drugs/alcohol?
- Supervision and line management arrangements?
- Training received and needed?
- Do they have information sharing protocols?

Description of role

- What is main focus of the competencies in team (eg. physical, mental health)?
- What style of service is offered (eg. office based, advocacy, hand holding)?
- Referrals: from whom and to where?
- Assessments used?
- Full list of all functions fulfilled (eg. liaison, direct work, interventions, police cells, consultation, training, promotional, work with families, custody, resettlement etc)?
- What training do they commission?
- When do young people get referred to CAMHS? Early Intervention? LD services? SLCN services?
- What health issues gets referred and in what circumstances?
- What types of help are provided by CAMHS/LD/SLCN/Early Intervention in Psychosis services?
- Do they complete any joint work?
- Emergencies – any written protocols?
- Access to psychiatrist for consultation?
- Access to paediatrician?
- Waiting time for a specialist service following assessment?
- Timescales for assessment work? Any protocols?
- Who does psychiatric reports for court?
- BME provision?
- Groupwork?
- Girls and young women?

Evaluation

- How do they evaluate impact?
- Service users' feedback and involvement?
- Do you have any leaflets for users?
- Exit interviews?

Perception of needs of young people

- What are perceptions of main health needs of young people?
- Which are met by YOT?
- If not, how are these needs met?
- Are there any unmet needs? What are they (locally and nationally)?
- What areas of need should the health practitioner focus on?

Glossary

ADHD	Attention Deficit Hyperactivity Disorder
AIM	Assessment, Intervention, Moving on programme
ASSET	A structured assessment tool used by YOTs
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behaviour Therapy
CHI	Commission for Health Improvement
DCSF	Department for Children, Schools and Families
DH	Department of Health
FIP	Family Intervention Project
GP	General Practitioner
LAC	Looked after children
LD	Learning disability
MAPPA	<p>Multi-Agency Public Protection Arrangements – multi-agency arrangements to monitor and review high risk individuals, including:</p> <ul style="list-style-type: none">• registered sex offenders required to register with the police• violent and sex offenders receiving a custodial sentence of 12 months or more, a Hospital or Guardianship Order, or subject to disqualification from working with children• others considered to pose a ‘risk of serious harm to the public’. <p>A statutory duty is placed on agencies to cooperate with MAPPA.</p>
MDTFC	Multidimensional Treatment Foster Care
MST	Multisystemic Therapy
PCT	Primary Care Trust

NCG	National Commissioning Group
NSPCC	National Society for the Prevention of Cruelty to Children
PSR	Pre-sentence report – a report ordered by the magistrates to assist with sentencing decisions.
PTSD	Post-traumatic Stress Disorder
SCH	Secure Children’s Home
SDQ	Strengths and Difficulties Questionnaire
SFSC	Strengthening families, strengthening communities
SHA	Strategic Health Authority
SLCN	Speech, Language and Communication needs
STC	Secure Training Centre
SQIFA	Screening Questionnaire Interview For Adolescents
SIFA	Screening Interview For Adolescents
YIP	Youth Inclusion Programme – funded by the Youth Justice Board to work with young people deemed at greatest risk of offending in a locality
YISP	Youth Inclusion and Support Panels – aim to prevent anti-social behaviour and offending by children and young people aged 8–13 years who are considered to be at high risk of offending
YJB	Youth Justice Board
YOI	Young Offender Institution
YOT	Youth Offending Team
YOS	Youth Offending Service
YJS	Youth Justice System

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